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MEDICARE REIMBURSEMENT TO RURAL HOSPITALS

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

MAY 4, 1989

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MEDICARE REIMBURSEMENT TO RURAL HOSPITALS

THURSDAY, MAY 4, 1989

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:07 a.m. in Room SD-215, Dirksen Senate Office Building, Hon. Lloyd Bentsen, (chairman of the committee) presiding.

Also present: Senators Matsunaga, Baucus, Boren, Bradley, Mitchell, Pryor, Rockefeller, Daschle, Packwood, Dole, Danforth, Chafee, Heinz, Durenberger, and Symms.

[The press release announcing the hearing follows:]

[Press Release No. H-17, April 17, 1989]

SENATOR BENTSEN ANNOUNCES HEARING ON MEDICARE REIMBURSEMENT TO RURAL HOSPITALS

WASHINGTON, DC—Senator Lloyd Bentsen (D., Texas), Chairman, announced today that the Finance Committee will hold a hearing on Medicare reimbursement to rural hospitals on Thursday, May 4, 1989 at 10 a.m. in Room SD-215 of the Dirksen Senate Office Building.

Bentsen said the Committee will examine the financial condition of rural hospitals and their ability to deliver health care to Medicare recipients.

"During 1988, a record number of rural hospitals closed, forcing Medicare recipients residing in those communities to seek health care elsewhere," Bentsen said.

Since 1984, 159 rural hospitals have closed across the United States, and a survey of hospital administrators suggests that as many as 600 rural hospitals could close their doors in the next five years. Fully 60 percent of rural hospital administrators believe their institutions are vulnerable to financial failure.

"These hospital closings often deprive people in rural areas of vital health care services. This is particularly true for older Americans enrolled in Medicare, because the elderly comprise 12 percent of the nation's population as a whole, but 25 percent of the population of rural areas," Bentsen said.

"One of the major contributing factors for the worsening financial status of rural hospitals is the Medicare prospective payment system. The criticism of PPS most often voiced by rural hospital administrators is the differential—12 to 13 percent—between what Medicare pays rural and urban hospitals," Bentsen said.

"It is imperative that we examine the problems with the Medicare payment system and to maintain access to health care for all Medicare recipients, and this hearing should be very helpful in that regard," Bentsen said.

OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS

The CHAIRMAN. This hearing will come to order.

We are holding this hearing this morning to examine those factors that have made it so difficult for our rural hospitals to stay open, to see what impact it has on health care for those in rural communities. This issue is of vital concern to the members of the

Finance Committee, to the Congress in general, and that is evidenced by the number of rural-hospital pieces of legislation that have been introduced.

Early in this session, Senators Dole, Baucus, and I introduced the Equity for Rural Hospitals Act. That is aimed at providing urgently needed short-term relief for the escalating problems faced by rural hospitals and by long-term structural reform of the Medicare payment system.

This legislation now has 55 cosponsors. That includes the Finance Committee members: Senators Mitchell, Rockefeller, Durenberger, Daschle, Heinz, Danforth, Wallop, Boren, Moynihan, Pryor, and Riegle. Senator Baucus and Senator Daschle have also introduced legislation aimed at addressing other rural health problems.

We are witnessing a rapidly escalating situation which could seriously jeopardize access to health care for six and a half million elderly Americans residing in rural areas. In 1988, 43 rural hospitals closed across the United States, bringing the total number of closures in rural areas since 1984 to 159.

My home State of Texas has the unfortunate distinction of having led the nation in closures, with 19 hospitals closing their doors last year. This problem isn't just confined to Texas, though; the situation is acute in all States with rural populations, and the problem is growing.

Almost 60 percent of the administrators of the rural hospitals believe their institutions are very vulnerable to financial failure. Medicare is a Federal program whose goal is to provide health care to all elderly Americans, regardless of where they live.

Knowing that 25 percent of the elderly live in rural areas, and that in general the elderly use a disproportionate amount of health services, I am very concerned about whether the elderly residing in rural areas will have access to health care entitled to them under Medicare if you continue to have rural hospitals close.

Now, there are many factors which have contributed to that kind of financial distress and the subsequent closing of rural hospitals, including the Medicare Prospective Payment System. Each year since the creation of PPS, the financial status of rural hospitals has gotten worse, with more than half of rural hospitals losing money caring for Medicare patients last year.

Today we are going to hear from witnesses who can describe the difficulties facing rural hospitals, the impact of the hospital closures on those areas, and the innovative approaches that rural communities have undertaken to maintain access to health care for their residents.

The information that today's witnesses provide will be valuable to this committee, as we work to formulate strategies to improve and promote access to health care for all Medicare enrollees.

We are looking forward to hearing the testimony of the witnesses, but I would like to turn now to my colleague, the Ranking Member, Senator Packwood.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. Mr. Chairman, thank you.

As I look around this morning, I see the Senators from Oklahoma, Montana, Hawaii, Texas, Minnesota, and myself, Oregon—with the exception of Hawaii, all representing large geographic States with immense rural areas, which are—I don't want to say underpopulated, but—lightly populated areas.

We might as well start with a goal, rather than reasoning to a conclusion. That goal is: we are not going to let the rural hospitals simply go out of existence, so that people who now travel 25 miles to a hospital will have to travel 125 miles to go to a hospital. That isn't fair. And despite those who on occasion in the past have argued against Federal help, saying, "Life isn't fair," we are not going to let that happen.

In Oregon, 54 percent of the hospitals are rural. And while our closures have not been as numerous or as bad as Texas, there have been closures. So I think we are going to say, as we would say with eduction, we are not going to let the schools close and make children go 100 miles to school; if we have to subsidize smaller schools, and smaller hospitals—and I use the word "subsidy" without in any sense being pejorative since there is nothing "wrong" about the concept—we will make sure, one way or another, that there are reasonably close hospitals of adequate quality to take care of rural citizens.

We will have one witness today, Mr. Eric Buckland, who is the Administrator of the North Lincoln Hospital in Oregon, who can speak well to the problems we all face. They are not unique to any State. It is a problem we all need to solve.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

The order of arrival: Senators Packwood, Baucus, Durenberger, Boren, and Matsunaga.

Senator Baucus.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you, Mr. Chairman.

It is clear that we have come a long way in at least helping Americans recognize the plight of rural hospitals, Mr. Chairman, but it is also clear that we have a lot further to go if we are going to in fact level the playing field, so that people living in sparsely-populated America can in fact have the same quality of health care and the same access to health care that people have in the cities.

An interesting figure I found just a few days ago was that in 1987, of all the critical-access sole community provider facilities in America, half of them lost money. The total amount they lost across the Nation was $33 million.

Mr. Chairman, before this hearing is over, as a country we will pay more than that amount—$33 million—in interest payments on our national debt. In the next 2 hours in this hearing, interest on the national debt will be $33 million. That is, the total cost is not much, and we can help address it.

The second point is, the hospitals we are talking about are critical. Let me illustrate:

In Montana, there is only one hospital for every 2400 square miles. The State of Delaware has a total area of less than 2400 square miles. Yet Delaware, a State with a population less than Montana, has 13 hospitals. So as a practical matter, folks who live in urban areas, who live in more densely populated areas, have much greater access to health care.

There are lots of examples like that. The root cause of the problem I think facing rural hospitals is an urban bureaucratic bias and presumption in favor of urban hospitals against rural, for a lot of reasons:

One, those making decisions tend to live in the cities. They tend to take better care of their own, rather than knowing about or thinking about the problems facing rural America.

In addition to that, there is a natural bias in PPS against rural hospitals. And the fact of the matter today is that PPS pays 17 percent more to urban hospitals than it does to rural hospitals.

Rural hospitals have the added cost of paying additional money to get technicians to come to service their x-ray equipment and other medical equipment that is expensive. There is additional cost to get nurses and others to come, to be competitive; otherwise, those nurses will be working in the cities. There are a lot of costs that face rural hospitals that those who set up PPS weren't aware of, didn't know about, didn't think about.

Thank you, Mr. Chairman, for this hearing. We have got a lot of ideas, and I think we are finally going to get this thing solved. Thank you.

The CHAIRMAN. Thank you.

Senator Durenberger?

OPENING STATEMENT OF HON. DAVID DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Mr. Chairman, thank you.

Let me begin by saying that my recollection of the '88 campaign was of George Bush standing in Boston Harbor, Mike Dukakis sitting in a tank in Detroit, and you, Mr. Chairman, being in some little hospital in Texas. I wish I could remember the name of the town, but it is not as big as Detroit or Boston.

The CHAIRMAN. Well, there were several.

Senator DURENBERGER. There were several little towns? [Laughter.]

It was the only time during the 1988 campaign that I heard anyone speak out on behalf of rural Americans in some term other than "kicking dust in the drought," or something like that, and speaking about the subject that brings us together today.

Our Ranking Member on this side spoke about the size and the capacity of the system, and he is absolutely right, because it seems to me there are only two reasons why we at the Federal level spend time on these issues: one is access, and it is very, very different if you live in Montana or Oregon or rural Minnesota than if you live in Detroit or Boston; and the other is quality, which is an issue that I think is directly involved here, also.

The problem that I think we face in this hearing is the way in which Medicare has reimbursed since the 1983 reform, when we based the urban-rural differential on a presumption that the costs are different in the two areas, urban and rural. And in fact, the 1982 data showed you that those costs are different.

I have discovered, Mr. Chairman, during the 6 years now that I have dealt with this issue, that the costs were different for two reasons: One, because the conservative practitioner in rural Texas, and rural Minnesota, and rural Oregon was not charging the same overhead or the same margin over his costs that was going on in the big cities. I mean, with big cities, in effect, the sky is the limit. In a small town, you know those folks. I mean, you know what you can charge in good times, and you know what you can charge in bad times. And that is the history of charge-based. That is one thing. The second thing is, nobody could estimate this technological revolution that was going on, and all of the costs in the technology.

So, what I hope we are doing today is dealing with those two issues.

But I would remind my colleagues that this is only one part of the problem that we need to deal with in this committee. The other one is the issue of rural physicians.

My State is not an old State, but the average age of physicians practicing in rural Minnesota today is 57-57. I mean, you have got to offer some Canadian doctor $125,000 a year to get him to come and practice in a small town in what I think is the greatest State in the country. And I think we are all having similar experiences, like that.

The reason that we are being asked to change the reimbursement system for physicians is precisely that, that we need to deal with the realities, that they are not being appropriately rewarded.

The other issue that we are all going to have to face is the issue of nurses. I will venture to say that the cost of hospital care in this country will double in the next 5 years, just because we are finally beginning to deal with adequate compensation for nurses in this country. You are going to see strikes all over America this summer. I don't know whether it is going to start in my State or it is going to start in one of your States; finally, these nurses, who are predominately women, are realizing how we have kept the lid on the rewards for what they contribute to health care in this country. They are taking the lid off, and we are all going to have to pay for it in one way or another. I think that is a third issue, beyond hospitals, that we all need to deal with.

For the last, Mr. Chairman, I just ask that two items here, one a 1986 report that we did in the Intergovernmental Relations Subcommittee on "Governing the Heartland: Can Rural Communities Survive the Farm Crisis" —that is, how the impact of deflation and deregulation is raising the costs to rural communities to meet their needs—if that could just be made part of the file of this hearing.

And then, last year Tom Harkins and I did a Report to the Northeast-Midwest Coalition on "Tools for Coping with Change," which is sort of a preliminary report on what is happening to the heartland in this country. I think that, too, if you are willing, would be an appropriate part of the record.

The CHAIRMAN. We will make it a part of the files.

Thank you very much, Senator.

Next, Senator Boren.

[The reports referred to by Senator Durenberger and his prepared statement appear in the appendix.]

STATEMENT OF HON. DAVID L. BOREN, A U.S. SENATOR FROM OKLAHOMA

Senator **Boren**. Thank you very much, Mr. Chairman.

I want to join the others in commending you for calling these hearings, because, as has been said, the issue of health care is one of the most urgent issues that we will deal with in this Congress.

It is hard to encourage physicians and health care professionals to locate in those areas, and especially difficult, in many small hospitals that are losing money, to recruit qualified and dedicated medical personnel. We have a system in which people are being reimbursed more to locate in those areas which already have an excess of medical personnel, more than they are paid to locate and to practice in areas that are underserved.

Access to health care is not only a health issue, it is often the deciding factor in whether or not an area is attractive to new industry and economic development. The very survival, economically, of many small towns depends upon the survival of the hospital and the survival of adequate medical care in that area.

I have joined with other members of the Senate to form a Rural Development Task Force, in order to begin a new effort to meet the needs of rural America. We are seeing an emerging pattern of economic difficulty in rural communities that requires us to work together to assist in the recovery of these areas of our country.

I am pleased that in recent weeks a number of very important initiatives have emerged in Congress to address the crisis confronting rural hospitals around the country, and I am especially pleased to note, Mr. Chairman, that the majority of the members of this committee are also members of the Senate Rural Health Caucus, and have sponsored and cosponsored a host of bills already this year which focus on the special issue of rural hospitals.

As all of us know, since 1984, 159 hospitals have closed in rural areas across the country, and experts and analysts have predicted that as many as 600 hospitals in rural areas could close by 1994. We just can't sit by and allow that to happen.

I strongly support Chairman Bentsen's bill, S. 306, to minimize the differential between Medicare reimbursements to rural and urban hospitals. I have also added my support to a number of other bills to assist rural hospitals, especially those that are rural referral centers and sole community providers.

In this time of crisis, we have to do everything possible to rectify the unfair disadvantages built into the health care system and find ways to strengthen rural hospitals.

So, again, I appreciate your leadership on this matter. I hope we can craft legislation that will really move us toward a solution of this problem before it is too late.

I would ask unanimous consent, Mr. Chairman, that the balance of my statement might appear in the record.

[The prepared statement of Senator Boren appears in the appendix.]

The CHAIRMAN. Without objection, that will be done. Thank you, Senator.

Senator Matsunaga.

OPENING STATEMENT OF HON. SPARK M. MATSUNAGA, A U.S. SENATOR FROM HAWAII

Senator MATSUNAGA. Thank you, Mr. Chairman.

I just wish to join the others in thanking you and commending you for holding these hearings. Health care has been one of the most serious problems throughout the country.

Hawaii, is one of only two States in the Union—Alaska being the other—without a veterans hospital. We have finally gained the attention of the Department of Veterans Affairs which is sending a team to Hawaii to investigate the need. The over 110,000 veterans in Hawaii have been sorely neglected in their health needs. These hearings would hasten the process of examining the rural components of this problem.

I thank you.

The CHAIRMAN. Senator Symms.

OPENING STATEMENT OF HON. STEVE SYMMS, A U.S. SENATOR FROM IDAHO

Senator SYMMS. Thank you very much, Mr. Chairman.

Mr. Chairman, I will summarize my statement and insert the entirety in the record.

But I want to pick up on what Senator Baucus pointed out about the size of Montana. Now, Idaho is not as large as Montana. We have a population of about a million people. Last week when I was home, I met with about a third of the State's rural hospital administrators—in the panhandle region of the State—where they indicated to me that many of these hospitals are simply going to close.

Now, it may well be that we can't keep all of these hospitals alive, no matter what we do here in this committee; but I want to put this into perspective. We have 45 hospitals in Idaho. Only two of those hospitals are classified as "urban," the two in Boise. We have Pocatello, which should be classified as urban, but because of a street and an annex—we need to annex another little city into Pocatello that is part of Pocatello, and then it would be urban. But otherwise, there are two hospitals in Boise that are making ends meet. The rural hospitals are all losing money. Coincidentally, they lost $33 million, the same as Montana, last year in underpayment from Medicare.

But to put this in perspective, Idaho, even though it is not as large as Texas and Montana, could encompass the States of Maine, Connecticut, Vermont, New Hampshire, Massachusetts, Rhode Island, New Jersey, Delaware, and Maryland all inside its boundaries. So, if we only had two hospitals survive, theoretically, then a person might have to travel from Maine to Maryland to get to the hospital. I think if you put it in that perspective, you will realize that this is a major, serious problem. We simply have to resolve this situation.

Mr. Chairman, I am pleased that you and Senator Dole have introduced legislation on this issue; but I do think that we have to be very careful in the passage of this with respect to what the formulas are, what wage index is used, or some of our States' hospitals could still end up not getting compensated enough to keep their doors open.

Like I said, maybe it is impossible to keep all of them open, but it will be a serious downward trend in the quality of life for people in rural communities if they find themselves without adequate health care for basic medical needs that are necessary in our society.

Mr. Chairman, I appreciate the fact that you have called these hearings. I think we can do something about it. I want to work with you and the rest of the committee to see that we do the best we can to resolve this problem for our rural hospitals. There is no issue in my State that is more important than this one.

I thank you very much for the opportunity to be here.

The **Chairman**. Commenting on Senator Dole, I was with him earlier his morning as he was meeting with the Prime Minister of Canada. He is still meeting with him, as Minority Leader, and wants very much to be here. He will be here as soon as that meeting ends. He has been a strong coworker in working up this legislation.

Now I will call on Senator Daschle.

OPENING STATEMENT OF HON. THOMAS A. DASCHLE, A U.S. SENATOR FROM SOUTH DAKOTA

Senator **Daschle**. Mr. Chairman, I was inclined to talk about the size of my State; but, given the fact that the Chairman is a Texan, I think that ultimately we all appreciate the advantage of size and relativity—[Laughter.]

And I don't think anyone needs to go beyond that.

We have all expressed the seriousness and the gravity of this situation. I don't know that I can add anything to it, except to say that in my State we have 54 hospitals, and virtually every one lost money last year. We had a negative profit last year in South Dakota of 7 percent.

As I look to the reason—with all of the right decisions that were made in this committee and in the Congress over the last 10 years, and certainly since Medicare has been enacted—it has to be that some time, at some point, we were persuaded that there is a reason for the differential between rural and urban hospitals.

I don't know how that reason came about, but I do know this, that there is no single decision that we have made in public policy affecting the Medicare program that has had a greater and more devastating effect on the reimbursement rates for our hospitals.

The fact is that there are two kinds of reimbursement. Max talked about the 17 percent. I don't know if it is 17 or 11 percent; I was under the impression that it was 11 percent. But that is the unexplained differential. There are still other differentials, wages and many other factors, that add far more to the 11 percent, to the point where in South Dakota we have got differentials between urban and rural hospitals that border on 40 percent in some cases.

So, I really think that we have to take great care in defining what this differential is, how this unexplained differential of 11 percent got there in the first place, and whether it is good public policy to allow it to continue.

The other point I would make is one that Senator Durenberger began talking about that is right on target, and that is the need for recruitment. He mentioned doctors and nurses, and I would like to take that even further:

We have come to the realization that we can't even get Canadian doctors. We have an African doctor in South Dakota who has considered coming to one small town, Martin, South Dakota, because that is the best they could find, and they are glad to have him. But we can't always go to Africa or Latin America or China, or someplace else, to get doctors. We have come to the conclusion that the best we are going to do is physicians' assistants, and the best we are going to do is nurse practitioners, and if we get that, we will be lucky. But we even have a shortage with nurse practitioners and physicians' assistants, a dramatic shortage.

So we have got to find a way to adequately recruit the personnel needed to come to rural areas as quickly as we can.

The last point I would make is this: We had a very successful One-Hundredth Congress. I don't know, under the tutelage of any Chairman, under the leadership of any Chairman, when we have had a more successful 2 years than we have had the last 2. We took on four major issues, and we knocked the socks off of most people in this country as they watched what happened in this committee.

If there is one thing that we do this year that will equal in consequence the impact that those four things had across the board, in my State, it will be to successfully address this issue in the Hundred and First Congress. Nothing is more critical than that. And I hope, with the same success and the same panache that we have seen from this leader on those issues, we can show equal progress on this one.

Thank you.

The CHAIRMAN. Senator, you can talk as long as you want to. [Laughter.]

Senator SYMMS. I do have a few more points. [Laughter.]

The CHAIRMAN. Thank you very much.

Senator Pryor.

OPENING STATEMENT OF HON. DAVID PRYOR, A U.S. SENATOR FROM ARKANSAS

Senator PRYOR. Yes, sir, Mr.Chairman. Thank you.

Mr. Chairman, I have a statement I will not read, and I would ask that it be placed in the record at the appropriate point.

The CHAIRMAN. That will be done.

Senator PRYOR. Mr. Chairman, also I would like to ask unanimous consent that the executive summary, which is just six and a half pages of facts and figures gleaned from an October 1988 Aging Committee staff report be placed in the record at the appropriate time and at the appropriate place.

The CHAIRMAN. I am sure that will make a meaningful contribution. It will be done.

[The executive summary appears in the appendix.]

Senator PRYOR. I might also add a note, Mr. Chairman, that in an Aging Committee and field hearing I held in Pine Bluff, Arkansas last year, we could not seat all of the people who came to testify and to listen to the problems of rural hospitals.

Of the 43 rural hospitals that closed in 1988 across America, three of those hospitals, Mr.Chairman, were from the State of Arkansas.

I recently availed myself of an opportunity to meet with a rural hospital board. It was 3 hours. It was their monthly meeting. And I can tell you first-hand, Mr. Chairman, that rural hospitals and rural health care is in a critical situation, that 83 percent of the hospitals today that are losing money are rural hospitals, and we must correct this situation.

Mr. Chairman, finally, Senator Durenberger mentioned a point a while ago, going back to 1983, when we based this differential on an assumption.

Let me say, respectfully, I think it is time for us, to basically admit that that assumption was wrong. We made a wrong calculation, and I think we have got to go to the heart of that matter and admit that that assumption was wrong, that we can charge these differing rates and have everyone come out having been treated fairly. I don't think we can treat them fairly.

We have a situation in my State where two hospitals are 14 miles apart —14 miles apart. One of them is classified as urban, one is classified as rural. The urban hospital is in the black, it is making money; the rural hospital is faced with actually closing its doors in the next several months, unless something is done—30-35 percent differential for the same treatment, the same number of days, the same State, the same procedures, and it is just not fair.

Mr. Chairman, I am so proud that you have introduced this legislation and that we are holding this hearing this morning. I hope we can pass it very quickly. Thank you, sir.

The CHAIRMAN. Thank you very much.

Senator Heinz.

OPENING STATEMENT OF HON. JOHN HEINZ, A U.S. SENATOR FROM PENNSYLVANIA

Senator HEINZ. Mr. Chairman, first I would ask unanimous consent that my entire statement be part of the record.

The CHAIRMAN. Without objection.

Senator HEINZ. Second, in the interest of candor, Mr. Chairman, let me say, as a cosponsor of your legislation, that I fully support it. It is very good legislation and I hope it passes. I don't want to delay it. I will be brief in my remarks.

Dave Pryor has said that there may have been some things we did wrong, and he is right. One of the things that we thought we were doing when we put in DRGs and PPS was squeezing excess beds, and therefore excess costs, out of the health care system. There may be some urban areas where this was and may even still be justified; but if you squeeze a rural hospital out of existence when it is the only hospital for 100 miles around—as it is in many parts of my home State of Pennsylvania, which, with three and a quarter million Pennsylvanians living in rural areas, has the largest rural population of any State in the Nation—it is not a question of going across the street to the other hospital.

One of the things that has made it particularly tough is the fact that, rural hospitals, in areas where the cost of living is in theory cheaper, still have to compete for the very same resources, have to pay the very same prices for a cat scan or some other high-technology piece of equipment as the hospitals in major metropolitan areas that get a higher reimbursement rate. They have to pay competitive salaries for doctors and nurses and also face a nursing shortage. Those costs are all going up.

In one sense, there is very little the government can do about that, except to recognize those realities. I don't think we intended to make DRGs a chopping block for rural hospitals, but that is what they are becoming. If anybody doubts that statement, just look at what has happened to profit margins: in 1984 rural hospitals had an 8.0 percent positive profit margin. This year it is a negative 0.6 percent profit margin, and the comparable numbers for urban hospitals is 15.5 percent and 5.6 percent—positive.

I am concerned, just as all of us here are, that we are going to continue to see rural hospitals close; 159 of them have closed so far, including some in my State. Another 600 rural hospitals, out of a total population of roughly 2,000, now down to about 1,850, may close within the next 5 years.

So, I hope, Mr. Chairman, that this hearing not only lays whatever needs to be laid upon the record, but that we can move promptly with your legislation.

[The prepared statement of Senator Heinz appears in the appendix.]

The CHAIRMAN. Thank you.

Senator Rockefeller.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER, IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Mr. Chairman, I submit my statement for the record.

The son of a very good friend of mine, his 18-year-old son, had a terrible accident on top of a mountain in the rural part of West Virginia. It involved his stomach, his spleen, and massive internal bleeding. You couldn't get him out by helicopter, because it was on top of a mountain and there was fog, as there often is in West Virginia.

They took the young man by car, which is the worst thing you can do when you have that type of internal hemorrhaging, to a rural hospital in Elkins, West Virginia, where he stayed for a day. They stabilized him, and then were able to Medivac him to the hospital at the University of West Virginia. He is now alive.

The doctors at the hospital at the University of West Virginia, and the doctors at the rural hospital in Elkins, West Virginia, agreed that had it not been for that rural hospital, and the stabilization that took place there, that 18-year-old young man would be dead today.

That hospital used to be two hospitals. They merged into one, because they couldn't afford to exist in the community of around

7,000 people, and they are now on the brink. I think last year they lost a million and a half to two million dollars. They are in crisis. I saw one young man's life saved. I grieve for those instances when there is not a rural hospital to save a life. I thank the Chairman.

The CHAIRMAN. Thank you, Senator Rockefeller.

As I stated, Senator Dole was doing his utmost to be here as soon as he finished his meeting with the Prime Minister. He has been a very strong proponent in helping on this piece of legislation, and I am delighted to welcome him.

Senator Dole.

OPENING STATEMENT OF HON. ROBERT DOLE, A U.S. SENATOR FROM KANSAS

Senator DOLE. I want to particularly welcome Mr. Erickson who is here from Kansas, who will be a witness this morning.

I would ask that my statement be made a part of the record.

The CHAIRMAN. Without objection.

Senator DOLE. I want to commend the Chairman and others who have cosponsored legislation to address the problems, of rural hospitals, whether it is the payment differential, or transportation costs, or their low patient volumes.

In my little home town of Russell, Kansas, I think we have an average of about seven or eight patients in a 30-some-bed hospital; but I share the views just expressed by the distinguished Senator from West Virginia. In many cases the rural hospital is not only important from the standpoint of the medical service, it is also the largest employer.

It is much like years back, when we started losing the little red schoolhouse; once you take the hospital out of a small town, you have pretty much taken the nerve center out of the small town.

So I hope we can find a way to save some of these institutions. I know that Senator Bentsen and Senator Packwood and others on this committee all share that view. I certainly want to be helpful, and I thank you very much for having the hearing.

[The prepared statement of Senator Rockefeller appears in the appendix.]

The CHAIRMAN. Thank you.

Senator Harkin, we appreciate your patience. You can see the deep concern of so many members on this issue. You have been one who has exercised a great deal of leadership on the issue—a man of compassion who has understood these concerns. We are very pleased to have you.

STATEMENT OF HON. TOM HARKIN, A U.S. SENATOR FROM IOWA

Senator HARKIN. Thank you very much, Mr. Chairman.

I am delighted to be here. I want to thank you for your leadership in sponsoring this legislation to address the problem of the differential, and for allowing me to appear before you this morning on behalf of the 67 members of the Senate Rural Health Caucus, which I might point out is chaired by Senator Dole and Senator Burdick. Senator Burdick had to chair another hearing and asked me to be in his place.

I will summarize my remarks. I just want to point out that I have been crossing out things here in my remarks as I have been listening to everybody up here talk, because they have said everything that I was going to say.

It really is a delight to see so many members of the Finance Committee who represent, very heavily, rural areas. Listening to you all speak, I know you are very sensitive to this issue out there.

Again, we all know the facts about rural America. A quarter of our population, a third of our elderly, and one-half of our poor people live in rural areas. The fact is, rural senior citizens pay the same for Medicare premiums as those living in cities. I guess we have to ask the question, shouldn't they have the same kind of access? But that access isn't guaranteed. As was stated many times here, 159 hospitals have closed, Mr. Chairman, as you pointed out, since 1984—two of those in my State.

Mr. Chairman, I believe that Medicare's Prospective Payment System is a major cause of this situation. The PPS system is based on the law of large numbers, and rural hospitals just don't have that many patients.

Is the PPS system biased? Well, just look at the balance sheet. Just half of the PPS hospitals are urban hospitals—one half are urban—yet, they receive 83 percent of the Medicare payments. And what is even more onerous than that is that their payments average 40 percent more for each case. So it is not just the 11 or 12 or 13 percent that was built into the law, it really is about 40 percent more, average-wise, for each case. In addition to that basic differential, the urban hospitals get 96 percent of the teaching payments, they get 96 percent of the disproportionate share payments, and 92 percent of the outlier payments.

In my home State of Iowa, in 1987, 34 hospitals in urban communities received 86 percent of the payments for inpatient care; while Iowa's 93 rural hospitals received only 14 percent of the payments for inpatient care.

Senator Symms said I also met with a number of my rural hospital administrators a few weeks ago; and, while they had been living with this for the last several years, they have now said, "This is a crisis." They are on the brink of going under unless something is done about this system.

This system of separate but equal payments to urban and rural hospitals is not working; and, quite frankly, rural hospitals deserve equity with the urban hospitals.

Mr. Chairman, I have cosponsored your bill to eliminate the urban-rural differential. Your bill takes a balanced, thoughtful approach to reforming Medicare hospital payments over the next few years. But Mr. Chairman, let me just repeat to you what my urban hospital directors said to me:

"We can't wait any longer. We thought, three years go, we could wait, and we did. A couple of years ago, we could wait, and we did. But this year we just can't wait any longer." That is what they are telling me. They need equity now.

Mr. Chairman, along with others I am introducing a resolution calling for elimination of the urban-rural differential now—as soon as possible—so that we can try to close this gap between the rural and urban hospitals.

To protect access to care for our elderly in rural areas I am supporting an access index for critical-access hospitals. I support also and am a cosponsor of the Baucus bill, on the sole community hospital situation. But an access index would recognize the hospitals that are vital to maintaining services to remote areas or to special populations.

In closing, Mr. Chairman, when I think about what Senator Dole said—about the fact that these hospitals, in many cases, not only are health care providers but are the biggest economic entity in some of these rural areas—I am reminded of a report I did several years ago, actually before I was in the Congress, on the establishment of the Rural Electrification System in America.

I went to the Library of Congress, reading the debates that were held at the time about whether or not we ought to have a government-sponsored rural electrification program. At that time there were certain Senators and Congressmen, who were not from rural areas, who were saying, "Well, if people don't want to live there, they don't have to live there. You know? They can move out of there. We don't need to electrify rural America. There is nobody living out in rural America, why electrify it?" This is talking about the debates that were held back in the early days on that. "We don't have to electrify rural America—the few people there, if they want electricity, let them move to the cities." I am just paraphrasing some of the debates that were held.

Yet, we went ahead, and we did it. And look what that did for us. It spurred the greatest economic growth this country has ever had, in terms of businesses, hospitals, universities, all over rural America, and we have benefitted greatly from that.

The same situation happens right now with our rural hospitals and rural health system. If you don't have a hospital in a community, there is no business going to locate there; and a business that might be there when that hospital closes? They are moving out, because they have to have that kind of care.

So, for all of these aspects—to help the elderly who disproportionately live in rural areas, for economic growth, for just equity, so that all Americans are treated equally, Mr. Chairman, we need to reinvest in these rural hospitals, and we need to make sure that we close this gap between the rural and urban differential in the Prospective Payment System.

Again, Mr. Chairman, on behalf of the Senate Rural Health Caucus, thank you for this opportunity to testify. I will do whatever I can in my capacity, just as one Senator or as Chairman of the Appropriations Subcommittee on Health and Human Services, to commend, help, and support your legislation to close this gap as soon as possible.

[Senator Harkin's prepared statement appears in the appendix.]

The CHAIRMAN. Thank you, Senator. In spite of having to listen to all of our statements, you did a good job of supplementing it and adding to it.

Are there any questions of the Senator?

Senator Bradley?

Senator Bradley. Mr. Chairman, I just want to thank Senator Harkin for his testimony. I missed everyone else's, and I assume that he reiterated what many of the other rural Senators said, as the head of the Rural Caucus. I might not agree with everything he said, but I salute him for his advocacy.

Senator HARKIN. Thank you.

The CHAIRMAN. Any other comments? [No response.]

Thank you very much, Senator.

Senator HARKIN. Thank you very much, Mr. Chairman.

The CHAIRMAN. Our next witness will be Mr. Curtis Erickson, a Member of the Prospective Payment Assessment Commission, and the President and Chief Executive Officer of the Great Plains Health Alliance, from Phillipsburg, Kansas.

Mr. Erickson, I may interrupt your testimony. The Majority Leader, who has a responsibility on the floor, will be coming in a few minutes. I want him to be able to present his testimony.

Do you have any further comments about Mr. Erickson?

Senator DOLE. No. I am just happy to welcome Mr. Erickson.

Mr. ERICKSON. Thank you.

The CHAIRMAN. Mr. Erickson, if you would, proceed.

STATEMENT OF CURTIS C. ERICKSON, MEMBER, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, AND PRESIDENT AND CHIEF EXECUTIVE OFFICER, GREAT PLAINS HEALTH ALLIANCE, INC.; PHILLIPSBURG, KS, ACCOMPANIED BY BRUCE STEINWALD, DEPUTY EXECUTIVE DIRECTOR, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Mr. ERICKSON. Good morning, Mr. Chairman.

I am Curtis C. Erickson. I am pleased to be testifying today on behalf of the Prospective Payment Assessment Commission. I am a member of that Commission, and I am also accompanied this morning by Bruce Steinwald, Deputy Executive Director of the Commission.

I am also, in my working life, President and CEO of Great Plains Health Alliance, a group of 28 rural hospitals with headquarters in Phillipsburg, Kansas. We run 26 hospitals in Kansas, 2 in Nebraska, each if them having less than 50 acute beds; so, I believe I am particularly familiar with some of the problems we are discussing at today's hearing.

I live, as I said, in Phillipsburg, Kansas, which is about 85 miles northwest of Senator Dole's home town of Russell—to put in perspective where my location is.

Senator DOLE. It hasn't rained there since last August. [Laughter.]

The CHAIRMAN. Well, you are one day closer.

Senator DOLE. They say it is so dry in Kansas, the cows are giving powdered milk.

[Laughter]

The CHAIRMAN. Mr. Erickson, if you would, proceed.

Mr. ERICKSON. Thank you, Senator.

The Prospective Payment System has had a number of both anticipated and unanticipated effects—some positive, and unfortunately some negative.

One of the negative unanticipated effects has been on small rural hospitals. Certainly, PPS was not designed to discriminate against any group of hospitals; but, because of a convergence of changes related to medical practice, reimbursement policy, technological advances, and rural economics, to name the most important, rural hospitals have fared poorly under PPS.

Probably the most serious problem experienced by rural hospitals has to do with their decline in admissions and the fact that PPS is a volume-based per-case payment system. Hospitals with increases in patient volume are more likely to receive positive rewards from Medicare's Prospective Payment System. But over the last decade, as I will describe in more detail later in my statement, rural hospitals have lost patients. Some rural hospitals have seen admission rates drop earlier and faster than have other U.S. hospitals.

The Medicare Prospective Payment System is not the only problem. In addition to the significant decreases in admission rates and utilization of rural hospital services, there are several other important factors having an impact on rural hospitals. These include the increasing sophistication of medicine, the movement of services out of the hospital, referral of patients to larger hospitals for more complex services, and the shortages of necessary medical personnel.

In addition, the demographic and economic environment of rural communities is changing. An aging population, an eroding patient base, and a changing rural economy are among additional forces influencing the long-term liability of rural hospitals.

Hospitals located in rural areas make up about 48 percent of all U.S. hospitals, but they provide for about 24 percent of the care for Medicare patients. They receive 16 percent of all PPS payments.

An examination of the distribution of PPS operating margins show that 10 percent of rural hospitals experienced negative margins of 34 percent or lower in the fourth year of PPS. Twenty-six percent of rural hospitals had negative PPS margins for three or more years of PPS.

Since the third year of PPS, however, when initial PPS data began to be available, rural hospitals have been the primary beneficiary of PPS policy changes. Policy changes that you enacted to take effect in Fiscal Years 1987, 1988, and 1989 led to a 10.2 percent increase in rural hospital payments, compared to 5.1 percent for urban hospitals.

These policy changes included a higher update factor, discharge-weighted payment rates, and separate urban and rural outlier pools.

Rural hospitals received a higher update factor in the Fiscal Years 1988 and 1989. ProPAC has also recommended a higher update factor for the Fiscal Year 1990, which we hope will be favorably considered.

In spite of higher rural updates and other policy changes, per-case PPS payments to rural hospitals have not generally increased as much as urban hospital payments. This is because rural hospitals treat a less complex mix of patients compared to urban hospitals, and case-mix changes has been a major source of payment increases.

It is important to note, however, that, while rural hospitals have lower payment rates than urban hospitals, rural hospitals also have much lower costs than urban hospitals. Rural hospitals have average Medicare costs per case that are about 40 percent lower than urban hospitals. This cost difference existed before PPS and has continued at about the same level through the present time. It is parallel to the approximate 40 percent difference in average PPS payments between rural and urban hospitals.

An analysis prepared for ProPAC, under contract, studied hospitals that closed from 1980 to 1987. Generally, this study found that closed hospitals were more likely to be small. They had fewer admissions and lower occupancy rates than hospitals in years prior to closure, and they had higher costs and shorter lengths of stay than hospitals that remained open. Slightly less than half the closed hospitals were in rural areas; about 51 percent were in urban areas.

In closing, because we consider access to care in rural areas a critical concern, ProPAC has planned an extensive agenda to do future analytical activities in this area. We are going to study hospital closures, additional analysis of payments, costs, and margins, and we have a major research project underway to review Medicare costs over time and access for different types of hospitals.

The CHAIRMAN. Thank you very much, Mr. Erickson.

Mr. ERICKSON. There is no question that the problem is sever and, speaking on behalf of ProPAC, we are looking at it very thoroughly.

The CHAIRMAN. That is helpful. I will defer questioning by the members for the moment. I see the Majority Leader is here. If the audience thinks I am being deferential to the Majority Leader, they are correct, and to the Minority Leader. [Laughter.]

The CHAIRMAN. Because I am hopeful that we will get this bill out of this committee soon, and that they will have the good judgment to schedule this early on the floor.

So I now recognize the Majority Leader, Senator Mitchell.

OPENING STATEMENT OF HON. GEORGE J. MITCHELL, A U.S. SENATOR FROM MAINE

Senator MITCHELL. Mr. Chairman, thank you very much. If we didn't have that good judgment before your gracious remarks, we have since acquired that judgment. [Laughter.]

I think Senator Dole will agree with me that this is a very important issue. Our presence here today is an expression of our concern for this matter, and to demonstrate our support for the need for action with respect to rural hospitals.

I have a statement, Mr. Chairman, which I will ask be placed in the record at the appropriate point.

The CHAIRMAN. Without objection, it will be done.

Senator MITCHELL. I know, having travelled to several of the Western States, rural States, that the problem is acute there. It is in my own State, as well. We have had two hospitals close just within the past year in Maine. Most of our rural hospitals are experiencing severe financial distress, and I assume that to be the case in Kansas, Oregon, Texas, and all of the other States represented here.

We began, as you will recall, the process of an update change to accommodate the differential from which rural hospitals were suffering as part of the Budget Summit Agreement, and I know that this legislation, Mr. Chairman, that you and Senator Baucus have taken the lead on will carry us further in that direction.

I just want to say that this is a critically important issue. Every American ought to have access to adequate health care, regardless of where they live, and we simply cannot accept or tolerate a two-tier system which consigns those living in rural areas to health care that is less accessible, less affordable, and less adequate than that available to Americans everywhere.

So I am very grateful to you for your courtesy in permitting me to go forward, and to the distinguished Republican Leader for his presence here. I commend you and urge you to continue your action.

I commit to you, Mr. Chairman and all of the members of the committee, that, when this legislation is ready, it will have a very high priority for action on the Senate floor.

The CHAIRMAN. Thank you very much, Senator Mitchell.

Mr. Erickson, you were talking about a technological explosion taking place in hospital care, and you were also talking about a drop in admissions to hospitals, a higher degree of transfers and referrals.

Have we reached a situation where rural hospitals, instead of trying to deliver a wide range of services, are talking about more selected services to patients that they are capable of fulfilling? If that is the case, is it possible to develop some kind of a criteria to identify the critical-access facilities, where a broader range of services needs to be made available?

Mr. ERICKSON. There is a lot in that question, Senator.

First of all, let me wear my hat of President and CEO of the organization that I operate. There is no question of rural services, currently, in the kind of hospitals that we have in our organization. We are not dealing with many of the DRGs that are in the 477 that were established by PPS. We find that from 50 to 100 of those DRGs are being utilized in the rural hospitals. So, some of the technological advances, have, we believe, already moved out of most of our hospitals. So, we are taking care of the basic kinds of medical and in some cases surgical needs that residents of those rural communities have.

The problem we have got, of course, is the numbers. We find, in our system, about 40 percent of the DRGs are single-admission, in an entire year. So, the process of averaging that has been spoken to by a number of the Senators just doesn't work in that setting.

Certainly, at ProPAC—and Bruce Steinwald might speak to this—there is research that we are looking at that would give at least more information available for all of us in regard to how that movement has happened—by looking at patient-origin studies, and other things of that nature.

The CHAIRMAN. I supported a demonstration project which I think can be of some help to rural hospitals, and that is one where, via satellite, they do a diagnosis, with the physician in the smaller community and smaller hospital and then some university hospital doctors doing it via satellite, in communication with the local doctor. It seems to me it really has some merit and can help upgrade the quality of service for some of those rural hospitals.

Are there further questions of the witness?

Senator Packwood?

Senator **Packwood**. Mr. Erickson, you have catalogued all of the reasons that rural hospitals are gradually declining. Your reasons are pretty much those that we have all discovered in travelling around.

Absent some change of policy, the same problems are going to continue. More of them are going to close, whether or not that is associated with the further aging of the rural population, better highways so people can get to hospitals 50 miles away quicker than they used to, or other factors.

Should we, as a matter of policy, attempt to stem that hemorrhage of closures, or should we sort of say, "Well, that is the ongoing of civilization. More of them are going to close and probably should"?

Mr. **Erickson**. As President and CEO of my organization, we should stem that flow toward closure. There is no question, as I think some of the Senators have indicated, we can't sustain all of the hospitals in those areas; but there is certainly no question, we have got to have some mechanism to sustain the access. I think access to beneficiaries of Medicare has got to be considered as a very serious problem.

Senator **Packwood**. I thought you said at the start of your testimony that there is no question we can't maintain them all.

Mr. **Erickson**. That is right.

Senator **Packwood**. So, some are going to close?

Mr. **Erickson**. That is right.

Senator **Packwood**. What is the standard that we ought to use to make the decision to close or subsidize? We can subsidize these hospitals any number of ways, but what ought to be the standard for making the decision to subsidize? Seniority on the Finance Committee? [Laughter.]

Mr. **Erickson**. That wouldn't be bad. [Laughter.]

Senator **Durenberger**. That is what we have been using. [Laughter.]

Mr. **Erickson**. That is an awful difficult question to have an answer, on my part, in a very short period of time. But one of the things that we can look at, maybe, would be a serious study toward a different mechanism of paying the rural hospitals—and I represent less than 50-bed hospitals; I am more concerned there—than we are now using in the PPS. I think I gave the example: when you have 40 percent of the DRGs, single-admission, one person per year, the mechanism of averaging doesn't work. So maybe we are going to have to take a look at the process of—I don't know what—return to cost? Or a portion of that process.

Senator **Packwood**. That isn't the question I am asking. If we make a decision that we want some hospitals to stay open that would otherwise close, we can figure out a way to compensate them. I want to know what your standard ought to be for which ones stay open and which ones close.

Mr. **Erickson**. I don't have that wisdom. I really don't. I suppose the only answer is to have an outside process, maybe a return to some kind of a State organization that makes determinations. You know, there is no other way. There has to be some mechanism, and I guess you are almost saying a public utility concept type of thing, someone who would make a decision, as a group, a panel, in the State Capital, or in PRO, or in some mechanism that is already in place.

Senator PACKWOOD. Oh, I hadn't thought about that. We could sort of go to a base-closing commission concept. [Laughter.]

Mr. STEINWALD. Senator Packwood, could I supplement Mr. Erickson's answer?

I can't provide you a criterion, but the Commission will work to provide you with better information over the coming year on the extent to which closures represent a genuine access problem for rural communities.

Just as the averaging system doesn't work very well for small, isolated hospitals as a payment mechanism, the average margin is not a very good descriptor of the financial performance of rural hospitals under the Prospective Payment System. Therefore, the Commission urges you, in much of the work that it has done, to focus not so much on the average but to focus on the extremes. There you find that rural hospitals have much more extreme cases of financial difficulty than urban, even though the gap has been narrowed somewhat on average performance, largely due to actions by the Congress.

We will, through our study of closures and others, try to develop better information for you on the extent to which closures and identifiable characteristics of hospitals and their communities represent a real deterioration of access.

But as far as the criterion is concerned, of course that judgment will have to be up to you.

Senator PACKWOOD. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman.

First I want to congratulate Mr. Steinwald. I think that is right, too often here we are too concerned with the averages, and we forget about the tyranny of averages; because not only those isolated but those other cases that are away from the average are the ones we have to address here.

My basic question to you, Mr. Erickson, is: How comfortable do you feel about ProPAC's knowledge of the needs of rural America? Over a quarter of our seniors live in rural America, yet you are the only member of ProPAC who has rural health care facility experience, out of 12. Why shouldn't three or four members of ProPAC come from rural hospitals, so we have a better understanding of the needs of rural America?

I also am concerned about this point because, in listening to you, I don't yet get the sense that ProPAC has a definite solution to the problem; which leads me to conclude that perhaps ProPAC itself, you excepted, doesn't know enough about the problem, have to study it more, because too many members have urban experience and not enough have rural experience.

Mr. ERICKSON. I am one of 17 that is rural.

Senator BAUCUS. Well, that makes my point even more strongly.

Mr. ERICKSON. I tell people that the next small town person is from Louisville, Kentucky.

But there is no question, I think we have had a significant increase in the knowledge of the staff and other Commissioners because of concerns that I have had an opportunity to express. I have no way of saying that there should be more. Certainly, I would be very appropriately pleased if there were more rural representatives.

But I believe the ProPAC staff has become very concerned. I think there is an indication, as I have mentioned in my testimony—and the longer testimony has an elaboration on this—in which the update factors have been significantly higher, on an annualized basis, for rural hospitals.

Senator **Baucus**. Isn't it true that PPS was never tested in a rural area?

Mr. **Erickson**. No, I would say it was not. As I recall, and I have been in the business 34 years, I believe most of the testing was certainly not done in any rural areas——

Senator **Baucus**. Do you need a stronger affirmative statement from us to tell ProPAC to concentrate more heavily in learning more about and knowing more about the actual needs and access problems of rural America?

Mr. **Erickson**. I think it is a high priority in ProPAC now, and I wouldn't know if there is any necessity for any additional work. But it is definitely a high priority.

Senator **Baucus**. How high?

Mr. **Erickson**. Very high. This year there are going to be more studies looking at rural hospitals than we have ever had in the past years of PPS.

Senator **Baucus**. Can you raise it a little higher?

Mr. **Erickson**. We will do our best, Senator.

Senator **Baucus**. Thank you.

The **Chairman**. Senator Durenberger.

Senator **Durenberger**. Thank you, Mr. Chairman.

Senator **Dole**. Could I just ask a question?

The **Chairman**. Oh, yes.

Senator Dole.

Senator **Dole**. If you would just yield for one question, there is one way we could do that. It was hard enough to get one rural representative on ProPAC, I might add. We might change that law, add a few seats, and make certain they come from rural areas. That would be one way to address it, to indicate our concern. We could do that in this legislation. So, it might be an approach.

But I just wanted to comment on a figure that in fact Sheila called to my attention here, that she hadn't seen before and I don't know that I have seen before, that "rural hospitals have average Medicare cost per case at about 40 percent lower than urban hospitals." Could you elaborate on that a little bit, either you or Mr. Steinwald?

Mr. **Steinwald**. Yes, sir. I will.

That 40 percent average cost differential existed before the institution of the Prospective Payment System. Much of it is due to factors that are identifiable, and that are in fact reflected in the payment system: higher severity of illness in urban areas, higher wages—although the wage data that we are using is somewhat old and outdated—a greater commitment to financing the costs of medical education, to name a few.

Those factors are all built into the payment system; but there is a residual that may relate to the different styles of care in urban and rural hospitals, and that residual is related to the 12 percent differential that has been referred to earlier this morning. That is, when you take out all of the factors that are known to lead to the cost differences, you are still left with the 12 percent differential. That 12 percent differential was built into the payment system at its inception. That 12 percent differential is the focus of some of your deliberations on instituting statutory change.

The 12 percent differential is not well understood. It is not related to the cost of teaching or to differential wage rates, and to other factors that are identifiable. And yet, because it existed historically, it was built into the payment system and is appropriately, I believe, the focus of some of your deliberations as to whether it should be continued.

Senator Dole. That is all I have, Mr. Chairman. Thank you very much.

Thank you, Senator.

Senator Durenberger. Yes. That was going to be the line of my questioning—and you still haven't cleared up anything for me. [Laughter.]

Clearly, it says: "Rural hospitals also have much lower costs than urban hospitals." Can you describe for us, in language we can understand, what you mean by "costs"?

Mr. Steinwald. Most of our information is derived from the Medicare Cost Report, and therefore it relates to Medicare costs per case.

The major factors that bring about the lower costs in rural hospitals are: Lower case-mix indexes, which are part of the payment system; lower wage rates——

Senator Durenberger. Let me stop you right there.

Mr. Steinwald. Yes, sir.

Senator Durenberger. I am assuming, when I see "40 percent lower" that that is not an aggregate, that that is a DRG-specific. And Mr. Erickson just said he only sees 50 to 100 out of the 477 DRGs. Now, pick one of those 50 to 100—maybe Mr. Erickson can pick it and give it to you, Bruce—and you tell us that the cost in his hospitals are 40 percent lower than they are in an urban hospital, in some small but SMSA in Kansas. Can you do that for us?

Mr. Steinwald. The 40 percent includes the difference in cases, though. That is a big part of it. Now, if you take that difference away, you are left with—I am not sure exactly how much—say 25 to 30 percent. Part of that is explained by differences in average wages; but, as I have said, we are using very old wage data.

Senator Durenberger. Well, now, the wage data—is that something separate? We are supposed to be talking about a base DRG, adjusted by a labor index, adjusted by disproportionate share, adjusted by indirect teaching, adjusted by GME and all the rest of that stuff. Let us just talk about the base DRG.

Mr. Steinwald. Okay.

Senator Durenberger. The fact that you put one dollar value on it in Minneapolis, and you put another one in Fargo-Moorehead or Sioux Falls, and then you put a third one in one of his little 50-bed hospitals. And you say there is a 40 percent difference between the urban and the rural cost.

Mr. **Steinwald**. That is the average per-case difference, incorporating all of the factors that relate to differences in the average cost per case. But that 40 percent includes differences in severity, and differences in the mix of cases.

Once you take away the severity differences and all of these other specific things that I mentioned, then the differential reduces to the 12 percent.

Senator **Durenberger**. Okay. Well, I won't try to belabor that; but, maybe for the record we can struggle to make it clear. If we are down to 12 percent—and I only raise this because Bill Roper came out to Minnesota last August, and he came out with this 12-percent figure, you know? And he is meeting all of these rural hospital administrators, all over the place, who are saying, "No, it is 35 to 40," just like Mr. Erickson. "Thirty-five to 40." Old Bill says, "They told me 12." And after three days in Minnesota, he said, "My God, they must be wrong in Washington—you know?—because all of these people have agreed on it.

Now, maybe it is a semantic differential, and I suppose we need to struggle to define that. But with regard to the 12 percent, that is where we don't know the intensity of services that go into big city hospitals, the difference in the practice styles, and that sort of thing. Is that where all of that comes in?

Mr. **Erickson**. And labor. The wages are in that 40 percent. I think that is one of the significant differences, is the fact that we are using I think a blend between 1982 and 1984 wage data, and I think maybe that is included in the amount the hospital administrators are talking about in Minnesota. No question. And it is true everywhere. But 12 percent in the basic rate, if you exclude those other measurements, I personally believe is acceptable. That is the difference in the base rate itself.

Senator **Durenberger**. The reason this is important, then, is because you are also saying that there is a 40 percent difference in the average PPS per-case payments between urban and rural hospitals.

Mr. Erickson, what is justified? The 12-percent differential, or the 40-percent differential, in your opinion?

Mr. **Erickson**. Well, certainly somewhere more than 12 percent, because I think rural hospitals have had a significant increase in the labor market, that you have spoken to, and other Senators. That has been drastic in the last few years, I think. That needs to be put in the formula, and I think that is where ProPAC has said: the wage rate data used needs to be more recent than 1984.

So, if you put in those, it would be more than 12 percent. If rural hospitals have that difference in labor that I am sure we feel, and I am sure other hospital administrators have indicated the same. That would be more than 12 percent, then, no question about it.

Senator **Durenberger**. This is the last question.

Mr. Erickson, I know you are one of only 17, but here you are among friends—you are one of 20, at least. I mean, we are all in this thing together.

So, what are you telling the folks here? We ought to eliminate the 40 percent differential? Or we ought to eliminate part of it? Or what?

Mr. **Erickson**. I guess, first of all, we need to eliminate——

Senator **Durenberger**. As a member of the committee, what are you telling the committee? What are you telling us?

Mr. **Erickson**. Well, I would love to get the same rate that Wichita, Kansas, has in all of our hospitals, and that is about a $900 difference in the basic DRG rate, between Wichita and rural Kansas.

I do now understand, certainly, that there are differences in costs, apparently, that have built into that formula of Medicare, that will not allow the rural hospital to have exactly the same; but somewhere more than 12 percent needs to be put in, because the labor situation has significantly changed in the last few years, and that is not in the formula now.

I don't believe urban labor has changed as rapidly—well, we don't know. That is conjecture on my part, and we haven't seen the data. But I think that is what ProPAC needs to seriously look at, so that we can get some facts, and I think that is what Bruce spoke to.

The **Chairman**. Senator Symms.

Senator **Symms**. Thank you, Mr. Chairman.

I want to expand on the question that Senator Durenberger had asked. As an example Moscow, Idaho, is two miles from the Washington State line. On the rural rate in Washington State, they get 20 percent-plus more than we get in Idaho; yet, we compete in the same pool for nurses, doctors, et cetera. This problem grows deeper now.

Back to your point: They don't do open heart surgery in Moscow, Idaho, for example. They go to Spokane for that. That is why there is such a big difference. I agree with Senator Durenberger. To do an appendectomy or other treatments, the cost is not any different in Spokane than it is in Moscow, or in Coeur d'Alene. We are competing in the same area for nurses. This is the problem.

We are going to lose a lot of our hospitals. We simply can't compete. We had one that was closing last month, in Council, Idaho, which is a long way from any other community. The only reason it is not closed today is because a corporate constituent, Boise-Cascade, contributed $25,000 to pay the bills for a month. How long that will go on, we don't know.

And what about this wage formula? How much does your Commission do on the wage formula? Last year, for example, when we passed a 1-percent increase in Medicare here in the Congress, Idaho got one-tenth of 1 percent increase. We didn't get anything, because of the wage index.

Mr. **Steinwald**. Senator, ProPAC has urged two things, that haven't happened, that would at least ameliorate if not solve the problem that you have mentioned.

First, the way that the labor market areas are defined is very crude, and it doesn't distinguish between rural areas that are adjacent to urban ones and rural areas that are really rural. It also doesn't distinguish between the core parts of inner cities and the suburban rings of metropolitan areas. We think that it should. And if it would, then the equity of the labor adjustment would be improved.

We also believe that the wage data itself that is used to calculate that wage adjustment needs to be updated. Mr. Erickson suggested to you that he thinks that because we are using old wage data, it has worked to the disadvantage of rural hospitals that have had to compete in the same labor markets as urban.

If those two things were done—those are technical improvements that would redistribute payments—we believe it would help some of the problems that you have described; although, certainly it wouldn't solve all of them.

Senator **Symms**. Thank you.

Thank you, Mr. Chairman.

The **Chairman**. Senator Daschle.

Senator **Daschle**. Mr. Chairman, I think we are hitting on something that will either make or break the argument for your bill and others like it.

If I understand what our witnesses are telling us, there is a 40 percent differential, and much of that differential is explained.

If I could put a numerical value to the explained and the unexplained—and I want you to break in, if I am misinterpreting what you are telling me—approximately 28 percent of the differential is explained; 12 percent is unexplained. Is that correct?

Mr. **Erickson**. Right.

Mr. **Steinwald**. That is a fair statement.

Mr. **Erickson**. That is a fair statement.

Senator **Daschle**. All right. Of that 28 percent, which you just told Senator Symms, it is that part, the explained difference, that ought to be addressed, and labor in particular. That ought to be addressed in dealing correctly with the differential.

But even if you deal with all of the different ramifications within the explained part, which is 28 percent, you haven't addressed the whole problem, which leads me to the real question: Why, now, do we still need a differential for unexplained factors? It seems to me we ought to eliminate the unexplained differential.

If you can rationalize the explained, let us do it. If there are real differences, let us take them into account; we have to be fair here. But there doesn't seem to be any logical reason why the 12 percent unexplained differential ought to be included at all in the formula anymore.

Mr. **Erickson**. Certainly, as an individual, I agree that the 12 percent ought to be done away with. When that happens, because the process has been established as budget-neutral, that means it has to be taken out of the urban, and I have some sensitivity to that, in the fact that I——

Senator **Daschle**. Well, there are practical problems in dealing with the unexplained.

Mr. **Erickson**. Right. But yes, I agree with you, it ought to be done away with.

Senator **Daschle**. Senator Durenberger's question was, how much of what we now have defined as "the explained" do we take away? Well, I think you almost ought to reverse the question. We can deal with the explained, and clarify it, and maybe take some of it away; but if we have a compelling reason to deal with the unexplained, as I think we do, we ought to be able to find a way, then, to deal with this differential and the problems we have with the urbans.

But that is our problem, Mr. Chairman: Dealing with that unexplained part, that 12 percent, and finding a way, then, to convince the rest of the Congress about the equity of this situation.

Thank you.

The CHAIRMAN. Senator Pryor.

Senator PRYOR. Mr. Chairman, I am trying to get to the bottom of the issue of rural representation or the prospective Payment Commission.

Now, I would just like to go back to the basics here a moment. Who appoints the Prospective Payment Commission? Is that OTA?

Mr. ERICKSON. Yes, the Office of Technology Assessment.

Senator PRYOR. And how many rural representatives are there on the board? How many members of the board?

Mr. ERICKSON. There are 17 Commissioners, Senator. I am from a community of 3200, and I really would say that probably would be the only rural representative.

Senator PRYOR. In other words, you are the rural voice on the Commission?

Mr. ERICKSON. Yes.

Senator PRYOR. It is my understanding, also, that when these original appointments were made—I hope I am accurate in saying this—they said, "Let's don't have any rural members on the board." Is this correct?

Mr. ERICKSON. I am not sure that was said. As I recall the history, there wasn't any rural representative. I think Senator Dole was concerned about that.

Senator PRYOR. Senator Baucus, and Dole, and others.

Mr. ERICKSON. Yes. Right. And a nurse was appointed, also, at that same time.

Senator PRYOR. I don't want to start the Civil War over, but I understand they did not want a Southerner on the board. Is that correct? [Laughter.]

Mr. ERICKSON. I don't believe I will comment on that. [Laughter.] I don't know.

Senator PRYOR. In fact, my information reveals that they said they had a Southerner on the board. We said, "Well, who is that?" And they said, "Well, they are from Southern Maryland." So, I don't know if that is what you call "Deep South."

In your opinion—you have served on this board for a while—what would be wrong, and this is serious, with having the Senate and the House make these appointments, and taking the appointive power from the OTA? What would be wrong with that?

Mr. ERICKSON. I am not sure I have the ability to give a comment on that. If you did so, it would be fine with me. I really don't have any way of making a judgment on that, Senator.

Senator PRYOR. Well, Senator Dole mentioned a moment ago about maybe expanding the number of rural representatives, and it appears now we have a bias against the rural representatives being on the board.

I just want to throw that out as a thought for a possible amendment, Mr. Chairman. We will talk about that at the proper time. That is all the questions I have at this time.

Mr. ERICKSON. Senator Bentsen, I think you might check with some of the other members of ProPAC. I think they do feel that I have been able to at least offer some rural representation, and sometimes they have been concerned about that, I think. And I think the staff has done an outstanding job. But no question about it, different parts of the country, to say "rural" and be able to represent the totality of rural is pretty difficult in this country, as you well know.

The CHAIRMAN. Oh, I quite agree, Mr. Erickson.

Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Just going back to the so-called significantly lower cost, the 40 percent factor. I agree with what somebody said earlier, that as the numbers come out, that may or may not be the case; but what we do here is make public policy, and we don't have to be bound by formulas that come out of computers.

If you accept, as I do, the fact that rural hospitals are treated in a second-class manner under Medicare, by definition, it then becomes harder for them to offer services, attract physicians, attract nurses, attract patients and provide health care in general.

It is also interesting, I think, philosophically, that Medicare is a national program, and that beneficiaries everywhere pay the same premiums, they pay the same co-payments. Regardless of whether they come from the Bronx or whether they come from Butte, it is the same.

So, one could argue philosophically and from a public-policy point of view that it is Congress's responsibility to treat rural and urban hospitals the same, and I think perhaps there are ways to do that.

My question to you would be: Why is it not sufficient for Medicare to rely on other adjustments to PPS, for example, severity, case mix, teaching programs, and outliers?

I noticed, in teaching payments, for example, that urban hospitals get 98 percent and rural hospitals get 2 percent. Disproportionate share payments—urban hospitals get 98 percent, rural hospitals get 2 percent. So, can we make adjustments in your formula, which comes out of a computer, which makes it fairer to rural hospitals? Severity, case mix, teaching programs, outliers, for example.

Mr. ERICKSON. Of course, all of those could be addressed looking at the data in regard to the rural and urban difference. The outlier pools have been divided by the Congress in the last year. Rural hospitals have their own outlier pool. Certainly, on the medical education side, I think very little of that work is done in rural areas. I think that is why you see the differential, the 98:2 that you are talking about.

Again, the first thing that has to be done, I think, is the standardized amount has to be corrected, so that the rural-urban differential in the standardized amount, that 12 percent, is eliminated. That is the first step, no question.

In my own State, for example, the payment amounts between Wichita and the areas of rural Kansas are about a 27 percent difference. So, the other differences, that 12 or 15 percent, are basically the changes in the things you just described, Senator.

Senator **ROCKEFELLER**. On a personal basis, do you support the Bentsen-Dole Bill?

Mr. **ERICKSON**. Yes. I would have comments about it, but I support it in general, yes.

Senator **ROCKEFELLER**. Thank you, Mr. Chairman.

The **CHAIRMAN**. Thank you very much.

I am going to defer any further questions—if you would, give them to him for the record—because we have two panels of very distinguished members who will deal with many of these same questions.

Thank you very much, Mr. Erickson.

Mr. **ERICKSON**. Thank you.

The **CHAIRMAN**. The next panel will be Mr. Paul C. Rettig, Executive Vice President and Director of the American Hospital Association; Mr. Timothy Size, the Executive Director of the Rural Wisconsin Hospital Cooperative, testifying on behalf of the National Rural Health Care Association, from Madison, Wisconsin; and Kevin M. Fickenscher, who is he Director of the Center for Rural Health, University of North Dakota; Grand Forks, North Dakota.

Dr. Fickenscher, I am still not sure I am pronouncing your name right. Why don't you correct me?

Dr. **FICKENSCHER**. It is Fickenscher. It is one of those challenges in life, Senator.

The **CHAIRMAN**. Well, since I had trouble with it, why don't you start off?

Dr. **FICKENSCHER**. Okay.

STATEMENT OF KEVIN M. FICKENSCHER, M.D., DIRECTOR, THE CENTER FOR RURAL HEALTH, UNIVERSITY OF NORTH DAKOTA, GRAND FORKS, ND

Dr. **FICKENSCHER**. Mr. Chairman, Members of the Committee, it is a real pleasure to be here.

I have to tell you that I first testified before you back in 1985, and there were only a couple of Senators that showed up. Today, when I sat here in this room and saw almost all of the members of this committee show up, I really felt that maybe our time has come.

Senator **BAUCUS**. Including the leadership.

Dr. **FICKENSCHER**. That is right.

I really have to tell you that I am very, very pleased that virtually every member of the committee indicated that they felt we needed to do something on rural health, and particularly reimbursement for rural hospitals. I am very pleased to hear that. I think even our good Senator from rural New Jersey supported that. So I am very heartened by the support that we have here in the committee.

As a result of that, I am not going to spend a lot of time talking to you about equity, because I am going to take you at your word that you are going to do something about it. As Senator Daschle has suggested, the One Hundred and First Congress is going to deal with the issue of equity.

What I would like to talk with you a little about this morning—I can talk specifically about some of the questions that were raised, if you want, in the previous session; but I would like to share with you some thoughts and perspectives that I think we also need to talk about when we are talking about the future of the health care system for rural America.

First of all, there has been one very positive thing that has come out of the Prospective Payment system; and that is that we have come to learn that where we put our dollars is the kind of health care system we are going to get. If we put our dollars in urban America, then we are going to see health care move to urban America. If we put our health care dollars in specialists, we are going to get specialists; we are not going to get primary-care physicians. I think that is a real fundamental issue.

So you, who are guiding our nation on our health care system, need to be thinking about that, because the policies that you put in place are going to direct the health care system.

As some of you know, I am a member of the National Advisory Committee on Rural Health. We are deliberating on these very issues. Unfortunately, we have not yet finalized our final recommendations—that will be accomplished within the next three to four weeks—but there are some preliminary thoughts that I wanted to share with you.

First of all, the National Advisory Committee is at a point where we believe we need to do some short-term stabilization while we implement a more long-term solution. Your bill, in particular, proposes that we should phase out the differential. We would agree with that. But we also believe that we need to do something now for some of those rural hospitals; because, otherwise, we are going to have haphazard closure.

The other point is that we need to replace the differential with a single national rate, and that is where the committee is probably going to be coming out; that there should be some adjustments for severity—not intensity of services, severity of services—and other legitimate cost factors that can be identified, as was suggested earlier; that we need to get away from arbitrarily splintering our reimbursement system along the lines of geography; and that we also probably need to define, over the course of the next couple of years, a concept that is called "essential access facilities." There are certain facilities that we need to keep open, out in some of the frontier areas of Montana and in some of the other areas throughout the various States. We need to keep those facilities open, just to maintain access to basic health care services.

I think the National Advisory Committee is also recognizing that not every hospital should stay open, and that some rural hospitals should be allowed to close, but that that shouldn't happen on a haphazard basis.

And finally, I think we need to facilitate innovation and creativity.

Along those lines, what I would like to suggest is that there are a number of very innovative and creative things going on in rural America that we should look at as potential solutions for how we might deliver services in some of our rural areas.

One of the things that I think we need to do is encourage some changes in some of the fundamental missions of some of our rural hospitals. In Montana, where Senator Baucus is from, the Montana State Legislature passed legislation that created medical assistance facilities. Arkansas recently passed similar type legislation. It is being considered in Minnesota, and I am not sure what is happening in Texas and West Virginia; but the concept has really taken hold.

I don't think it is the end all and the be all for rural hospitals, but I do think that there is a lot of merit to it. The concern that I have is that Montana, despite taking the leadership in this particular area, is somewhat atypical—the frontier areas of Montana are not really typical of much of rural United States—and therefore we need a degree of experimentation.

So, one of the things I know Senator Daschle has been thinking about is introducing legislation that would encourage HCFA to fund six or seven States in looking at this, because we need to look at this from a broader perspective than just the frontier.

I also believe, as part of any legislation along those lines, that we need to encourage looking at different types of rural areas, not just frontier.

The other things I have outlined in my written statement, which I have provided to you. I guess the one thing that I would strongly encourage is that we also need to be looking at how we can have rural hospitals come together in networks and cooperatives, and the kinds of relationships that they can have with larger facilities.

There are lots of innovative things going on in New York State, Wisconsin, Texas, Kansas, et cetera, that are exploring the use of linkages in tying rural hospitals together. This is one way where they can maximize their resources and yet deliver the kinds of quality care.

With those few introductory comments, I would be more than willing to answer any questions later on.

Thank you very much.

The CHAIRMAN. Thank you.

Mr. Rettig, we are very pleased to have you. If you would, proceed.

STATEMENT OF PAUL C. RETTIG, EXECUTIVE VICE PRESIDENT AND DIRECTOR, WASHINGTON OFFICE, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Mr. RETTIG. Thank you, Mr. Chairman.

I am Paul Rettig, executive vice-president of the American Hospital Association and director of its Washington office. On behalf of the Association's nearly 5500 hospitals, I appreciate the opportunity to talk with you about the situation facing health care in rural America.

Many of the things I propose to say, and that you will find in my written statement, have been covered very adequately by members of the committee themselves, even before hearing from formal witnesses.

I just want to underscore the importance of rural hospitals to access and quality of health care for many patients in rural America. When a hospital is not there, there isn't the opportunity to stabilize patients in emergency situations or urgent situations. And as hospitals disappear, there is a tendency for the physicians and other health workers in the area to disappear as well, so that you have a loss of health care in the community generally.

As has been pointed out, you also have a situation in which the hospital is the key institution for the community, means many things to the community, and its disappearance can have devestating effects.

I want to say just a few things about the financial pressures facing rural hospitals. Some of these have been dealt with by earlier commentators, but let me just mention:

First, the obvious thing is that Medicare Prospective Payment is based on a law of large numbers, and that law does not work well for small rural institutions. In a sense, rural institutions are asked to be insurers, to bear some of the risk, as all hospitals are under Medicare PPS, but they basically are asked to do this in a situation in which they do not have adequate reserve funding—that is the analogy I would make to an insurance situation or an HMO situation—so that a few very expensive cases can have devastating financial effects on the institutions. That is an illustration of why looking at things in terms of averages does not often work for small rural institutions.

As has been noted, in many cases the rural institutions compete for health care personnel in a labor market where the reality is a little different from the lines that are drawn under Medicare PPS; so, you need to recruit from a distance, where the worker has the alternative of working in a metropolitan area where average wages may in fact be much higher.

The financial pressures also include the inability of many patients to pay. To the extent that rural America has a depressed economy, you have problems with the ability to pay. Insurance coverage among people living in rural areas I think is generally lower. Even in terms of Medicaid, the situation is that, on average, the lower income people are more likely to be in intact families not eligible for Medicaid.

So, a number of things conspire to make the situation difficult.

Like other hospitals, rural hospitals have responded to the incentives of Prospective Payment. They have moved care from the inpatient to the outpatient setting, they have changed in a number of ways that has had impact on their occupancy rates, their revenue, and so forth. They are trying to respond by changing their mix of services, providing more outpatient care, providing skilled nursing care, much more so than in institutions in the cities.

As has been mentioned before, we need to consider the possibility that Medicare itself and programs beyond Medicare may need to take special steps if it is desired to preserve hospitals in the rural areas.

Rural hospitals are nearly half of the nation's hospitals, but they account for a much smaller proportion of total admissions, of outpatient visits, and of total hospital expenses. For the very small rural hospitals, the American Hospital Association recommends consideration of allowing them the option of having cost reimbursement, since, as has been indicated, the law of averages does not work well for them. Because their share of the total expenses of America's hospitals is relatively small, the cost effect of doing this would be relatively small.

Now, the average operating margin under Medicare for rural hospitals for Fiscal Year 1987, or for the fourth year of PPS, is a negative 6 percent. So, on average, rural hospitals are losing 6 percent in their Medicare cases.

We need to point out, however, that this situation is shared by other kinds of hospitals. Small urban areas, large urban areas, all have situations in which on average the operating margins are turning negative.

The discussion in the committee about the 12 percent differential is of great interest to the hospital association. We support the notion of moving toward an elimination of that differential, the 12 percent unexplained. Over the long run, as is suggested by the Bentsen-Dole Bill, the Association recommends that we work to do away with that differential, so that you have a single standardized rate and not two separate compartments for urban and rural. We believe there need to be adjustments for case mix intensity in whatever legitimate adjustments there are, rather than start with that differential that has been so troublesome.

So, we are looking for a single base rate; we are looking for a refinement of the DRGs; we are looking for a more up-to-date area wage index, with an annual update. As mentioned, we are looking for an opt-out for small rural hospitals. We would extend the rural referral centers provision, and we would continue and expand the transitional care grants that have been part of legislation that has already been approved.

[Mr. Rettig's prepared statement appears in the appendix.]

The CHAIRMAN. Thank you, Mr. Rettig.

Mr. Size, if you would, proceed, please.

STATEMENT OF TIMOTHY K. SIZE, EXECUTIVE DIRECTOR, RURAL WISCONSIN HOSPITAL COOPERATIVE, TESTIFYING ON BEHALF OF THE NATIONAL RURAL HEALTH CARE ASSOCIATION, SAUK CITY, WI

Mr. SIZE. Thank you.

I really almost hesitate to testify, given, I think, the understanding your committee and all of you have. I would like to perhaps particularly support some of the strong questioning that occurred a few minutes before. I think much of that was on a very important track. Let me try to fill in a few extra ideas.

One thing I would like to encourage is the urgency of the situation. I had lunch yesterday with one of the 20 administrators on my board—one of the strongest, one of the most creative, one that has done the most diversification—and he, frankly, told me he was scared. He was worried. He just didn't know how much longer he could keep things going. This was not one of the weaker members of our co-op; this was one of the stronger members.

I would also like to support something that was said earlier, I think by Senator Durenberger. This is an issue of inequity, not only for hospitals but also physician payment. The rural hospitals I speak to plead as strongly for equity with physician payments as much as they do hospitals, because if we don't have physicians in our communities, it doesn't matter how clever we are as administrators, we can't do a lot.

I would also like to draw attention to the fact that, personaly, and I believe many others believe, the whole issue of severity as one of the "great explainers" is in large measure a red herring.

I am not a researcher, I am a co-op administrator, but what I have seen in terms of writing, even from the government itself, is that most of the explanation of what is called "severity" is in fact difference in intensity of resource utilization by physicians in urban areas. It is not that they are able to show that the patients themselves are more sick, but it is that, for the same level of illness, physicians in urban practices, for a variety of traditions and reasons, are using more resources as they treat those patients. That is a different issue. It is a hard issue, but it is not a severity of illness issue.

So, I would caution, when anyone speaks before you saying, "We need a severity of illness adjustment," you make real sure, before you make that adjustment, you are adjusting for severity of illness.

I would also like to go on and say that frequently we hear, most frequently perhaps from ProPAC, "Well, this 40 percent cost differential has been maintained." Well, of course it has been maintained. You paid rural hospitals less; to keep in business, they have had to spend less, or at least less as costs have risen. To not do so would have been foolish. So, the fact that there is research that shows the cost differential has been maintained, to me says rural hospitals and rural boards of directors have been behaving prudently, not that they are just simply less expensive.

These are a few remarks, in response to what has been said so far this morning, perhaps not so much for you, but knowing that you have other colleagues in the Congress who are less supportive. May I address my formal remarks to them through you.

We have seen a certain amount of blaming the victim. It is not just with hospitals, we see it with the homeless, we see it with the small rural towns, we see it all over. That (blaming the victim) has been used to justify, "Well, Medicare is not really the problem; it is a small problem. There are other problems." We know there are other problems. People like me, and Kevin, in particular, we have been working for years to try to get our programs, our services, our hospital, our clinics, working more effectively, more efficiently, more cooperatively. We know that. We don't have to be told by HCFA that Medicare is not the whole problem.

The analogy I guess I would like to draw here is that my oldest son is with me today—kind of a little applied civics lesson—and he could be using a little bit more time towards his homework. But if he comes home tomorrow with a broken leg from soccer, I am not going to say, "Well, I am not going to fix that broken leg, because you need to spend more time on your homework." And I am certainly not going to say, "Well, I think I will break the other leg while I am at it, too."

That is how a lot of us feel about the official, let us say, "other side" that doesn't think much needs to be done.

In my written testimony—I won't go through it now—I do point out a number of very important issues that are similarities between rural hospitals and inner-city hospitals. We are the odd boys out, and I think the formula works poorly for both of us. I think inner-city hospitals, at least earlier in PPS, did a better job politicking and getting their special needs met. But I think if you look at the underlying socioeconomic problems of inner city and rural, the politics are a lot difference, and sometimes the color is different; but the realities are very much the same. And I would hope that would be a political bridge that some of you as our rural advocates can make with some people who have more inner-city constituencies.

What challenges are unique to rural hospitals? One big one is that I think the basic Federal reimbursement concept favors urban economies. Let me read this, so I don't mess it up:

Rural hospitals and physicians are penalized for being inefficient, because they work on a smaller scale in geographically less populated areas. At the same time, they are denied the advantage of some lower input costs through deductions in Federal reimbursement formulas. These are the famous "input cost adjustments" which everyone just accepts as being okay. I would say maybe they are not okay, because the reverse is true for urban providers. Federal reimbursement formulas allow them to maintain the benefit of economies of scale, while protecting them from higher input costs.

What I am trying to say is that if we are going to adjust for input costs, let us also adjust for economy of scale. They very much belong paired together, and both the hospital and Physician Payment Systems have fragmented them, in both cases, to the detriment of rural.

One more major point, in terms of uniqueness for rural: We are becoming ambulatory care centers. Rural hospitals are not just places where you find beds; increasingly they are places where at least half of the activity is outpatient.

That leads me to a point that most of us have been missing, and we need a lot more data on, the whole issue of what is going on with the shift under outpatient from a cost basis to a fee basis. Many of my administrators up in Wisconsin, and around the country, are saying that is becoming a bigger problem for them, and they are projecting it to be a bigger problem in even the inpatient side. I am not sure we have given that as much attention as we need.

How are rural hospitals responding? We are doing a lot. I was flying with a friend yesterday, another corp. board member. Let me just read quickly the list of things he is doing in his hospital: He has created an emergency observation service; he has created swing beds, an intermediate care program, a respite care program, a home health care program, a companion care program—he is obviously targeting the elderly—a Medicare-certified hospice, elderly apartment living, independent living, day care.

Rural hospitals are diversifying. They are reaching out to their communities. We are just not complaining about Medicare.

In terms of what needs to be done, I think you all have a good idea of that. Obviously we have to get adequate payment, we need equitable payment, both the hospital and the physician. I personally feel we really ought to suspend any more creative changes in the outpatient side and keep them on costs, until we know what we are doing. I think we are heading for an exact repetition of what we did a few years ago with inpatient, by plunging into a new way of paying for outpatient and not really knowing what we were doing.

I will stop there.

[Mr. Size's prepared statement appears in the appendix.]

The CHAIRMAN. Well, I think that is helpful.

Rural hospitals are restructuring their health care services. What kind of barriers are they meeting, trying to bring about those kinds of transitions? And what can the Federal Government do to try to facilitate those kinds of rural innovations that you are talking about?

Mr. SIZE. I will give you one example. We have been fighting with Region V of HCFA about home health and hospice branch offices, Region V said, "You can't have a hospice service that is more than 8 or 10 miles away unless you recertify it on its own." So, we need regulatory flexibility. We need people to look at the concept of what we are trying to accomplish, in terms of protecting the beneficiary, and then to be flexible and make sense. We don't need blind obedience to regs that were written for an urban or suburban situation.

We need more loan-forgiveness programs, not only for physicians but physical therapists, nurse-practitioners. People are coming out of school with large debts, and then we penalize them for going to a rural area—probably one of the few countries in the world that has that philosophy.

We need more money in Senator Durenberger's Transition Grant Program. We are capital-poor. We don't have reserves. We understand we need to change, but we need capital to help.

Maybe you should ask some of the other folks, too.

Dr. FICKENSCHER. Let me add to that, if I could, Senator Bentsen.

The CHAIRMAN. Well, you loaded me up pretty good, I would say. [Laughter.]

Yes.

Dr. FICKENSCHER. You know, one of the analogies that I made is that we are trying to take rural hospitals, and we want to retrofit them. You know, when GM and Chrysler do retrofitting to change their factories to make different kinds of cars, they invest some capital, both in terms of physical resources but also in human resources. It think that is one of the fundamental issues that we need.

I think that Senator Durenberger's bill has gone a long way towards doing that, but it is way oversubscribed. We have so many rural hospitals that want to get access to those kind of things—and we are talking small dollars; we are not talking lots of dollars—that are going to have a substantial impact.

So, if there is anything you could do along those lines, I think it would really have some benefit.

The CHAIRMAN. I might say to Senator Pryor, who was asking earlier about the representation, that Senator Dole and I are the ones that pushed hard on seeing that we get rural representation here and pushed ProPAC to do that. And I further did that on the Physicians Review, when you were talking about payment there. Perhaps we should do more than we have thus far.

The particular piece of legislation that we have introduced has increased the authorization from $15 million to $25 million. The current funding, as you well know, I am sure, is $9 million. Although, as you say, that is not a lot of money, it is a significant increase over what it has been.

Now, because we are getting late, and we have been lucky on not getting caught with a Roll Call, I will dispense with the rest of my questions. I will turn to whomsoever.

Yes.

Senator BAUCUS. Just very briefly, Mr. Chairman.

I think this has been excellent testimony. I think the three of you have hit a lot of nails on the head, and I think it very much helped further the understanding of all of those who have heard you. I want to compliment each of you. I think it has been excellent.

As I listen to you, it becomes more and more clear to me that ProPAC needs a lot more rural representation to better understand some of the problems that you pointed out.

For example, you, Mr. Size, talked about questioning the severity factor, and that made a lot of sense. It makes sense to me that probably patients in urban hospitals, because there are more facilities, do receive more of those facilities, and therefore those patients are more costly. That is probably a fact. The economics of rural hospitals is a lot different than the economics of urban hospitals.

I think, too, to some degree HCFA is co-opted by larger urban hospitals, and there is probably an urban bias in HCFA because those folks live in cities, et cetera.

It just seems to me that we are going to have to legislate that about a quarter of ProPAC has to come from rural America, so that it will force the bureaucracy of not only ProPAC but of HCFA to better address the problems of rural America.

Now, each of you said that we can't wait, that this matter is urgent. I am wondering what you advise we do, quickly, to keep those hospitals alive that otherwise are going to go down the drain while we try to come up with something more substantial.

I believe, clearly, we should eliminate that 12 percent differential. Mr. Rettig, I heard you say that we should probably move back to cost-based reimbursement, on the base of need, anyway, for smaller hospitals. I understand that is only $100 million. That is all that would cost. That is not a lot of dollars, and it is going to save some hospitals.

But what else do we have to do in the interim, if anything, on a reasonable basis, to keep those smaller hospitals alive that otherwise will go down the drain?

Mr. SIZE. Well, I think one thing, we stopped talking about working to eliminate the differential, and, with due respect, make the timetable in your bill eliminate the differential and not to wait four or five years. I know a lot of people aren't going to last that long, who we probably want to stay around.

I think we need to look seriously at taking the 70 percent number and lowering it down. I think we have to ask ourselves should that be Medicare and Medicaid, because I think we all know what is going on with the Medicaid program.

I spoke in Reno earlier this week. Men came up from North Carolina and South Carolina who were disproportionate-share hospitals, who would not meet even some of the lower numbers on that Medicare screen, but who were already receiving disproportionate adjustments.

I think we need to really address the issue of the wage index. That is two-thirds of the problem. I realize the proposal has a committee set up to look at those hospitals that might be more appropriately urban; but that really doesn't get at the meat of the issue, that wage levels flow out like a hill for some types of people, and for some professional labor there are actually State-wide markets. I am afraid we haven't addressed with enough creativity, yet, the wage index issue, even with this very good legislation that you all put forward.

Senator BAUCUS. Thank you very much.

In deference to the time, I won't ask any more questions, either. Thank you.

The CHAIRMAN. Mr. Size, I want to say that insofar as that 70 percent, I certainly agree that we ought to try to pull that down to a smaller number, if we can find the money, and we will be striving very hard to do that.

Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman.

I might add that Dr. Fickenscher is going off to be the Assistant Dean of the Medical School at Michigan State. While you were in a small hospital, and one of the other guys was in the harbor, and the third guy was in the tank, he and I were flying around in a little Aztec in Minnesota trying to land in small towns in the fog. He said he was here in 1985, but he has really done a lot of work across America, in a variety of ways, and making us all more informed, as have the other witnesses.

My question is simply this: Is there a consensus on this panel that we ought to go to a single base rate for DRGs for hospitals in this country? And is there agreement on what goes into that base rate? Or do you know of any disagreement among you on what should go into that base rate?

Mr. SIZE. I think we should be at the base rate as a starting point, and then we have to attack how much of "the other explained difference" is explainable but not acceptable. That is the wage issue.

Senator DURENBERGER. Well, its severity—you are not so sure about severity, but Kevin says, yes, we ought to have a severity test adjustment.

Mr. SIZE. I think we should.

Dr. FICKENSCHER. But not intensity. I was pretty specific about that. That is where I think there would be some disagreement, because I heard Mr. Rettig talk about intensity of services.

I would agree with what Tim Size just pointed out, that a lot of intensity is the use of resources that just happen to be in your facility. And if we penalize rural hospitals by saying, "Well, we are not going to reimburse you for having certain kinds of resources, you are not going to be able to afford to get those resources," it is sort of a downward spiral; it is a self-fulfilling prophecy. And I think that is the fundamental issue that Mr. Size and I are talking about.

At the same time, I recognize, having worked in urban hospitals—I mean, I took my residency training in the Bronx in New York City—I know what a big hospital is all about, and there are some severity kinds of problems that do exist. So, for those legitimate kids of differences, there probably should be some sort of differential.

Senator DURENBERGER. Well, I think if this hearing illustrates nothing else, it is the fact that this committee is ready to go. But we are going to need some help from the folks in the hospital business to agree on what goes into that national average. There are a lot of folks out there who think we are going to write checks for the same amount in Chicago and in some Hettinger, North Dakota, and we are not.

But I believe we need some consensus on what that base rate ought to be, and then on what the adjusters ought to be. And I am sure it is not going to be resolved now. I mean, the Chairman certainly hopes it is not going to be resolved now.

I would hope you could submit, for the record of this hearing, an amplification of your remarks, an indication of what adjusters ought to go in there. It would certainly help the Chairman and the rest of this committee a lot.

Dr. FICKENSCHER. I agree with you, Senator Durenberger. I think you are raising a very legitimate issue, that the industry needs to come forward with some resolution to that.

At the same time, the whole severity portion of the percentage that we are talking about is a very small percentage. We are talking the area wage index and all of that, which is a major problem, is a far larger percentage.

And this 12 percent unexplained? I guess my feeling is, in Texas they grow wheat, and they grow wheat in North Dakota. And the cost of growing the wheat is different. But in our agricultural bill we don't say, "Well, because the cost of wheat is different"—and we can't explain it; we don't know why—"we are going to pay different on a per-bushel basis." I think that 12 percent should be done away with.

Mr. RETTIG. We think that the area wage index, and more timely updating, and any improvements that can be done, are very important.

Also, with regard to what is sometimes described as a severity or intensity issue, it is our understanding that there is a kind of second-generation revision of DRGs that is coming out of Yale that shows a lot of promise and that, if the promise is fulfilled, may help to solve many of these problems.

Senator DURENBERGER. I think the last point, Paul, directed at you, in your statement it says—and this is understandable from an association—"We can't support efforts to achieve a base rate simply by cutting urban hospital payments to increase rural hospital payments." I am sure you mean by cutting the increase, or something like that. But the reality is that the American hospital associations—in the plural—are going to have to help the folks on this committee deal with the issue of that 12 percent, which is apparently attributable to the differences in intensity, as it is being called here, practice styles, a whole lot of other things.

Just because the New York City hospitals have 102 percent occupancy does not mean that they have got that many more sick people in New York City; it means that they practice medicine a very, very different way, and they are asking Medicare to subsidize some substantial part of that extra occupancy. Right now it is coming out of the rural hospitals, to help them out; and yet, we always get this, "Don't take it out of the urbans." Is there any hope that that will change?

Mr. RETTIG. What you say is absolutely correct, and it would have been easier some years back to say, "Let us, in any kind of a zero-sum fashion, shift from one place to another."

What we observe now, however, is that there are negative Medicare operating margins for all three compartments, if you want to call it that—rural, small urban, and large urban. So that makes it very difficult to say, when they are all losing money on Medicare, that you should take from one and give to the other.

Our proposal, therefore, suggests that to really do the job right you need more money in the system.

The CHAIRMAN. Thank you.

Are there further questions of these witnesses?

Senator PRYOR. Mr. Chairman, if I could ask three quick questions to be answered in writing, I will not burden the committee with long answers.

The CHAIRMAN. Fine.

Senator PRYOR. I would like to read the questions, so the witnesses could be thinking:

(1) Is there a disproportionate burden of proof for rural America and the rural hospitals vis-a-vis urban America and the urban hospitals in proving a difference in cost? The burden of proof issue is one that I think needs to be addressed.

(2) Is 1994 a proper time, is it an adequate time, for us to phase in this legislation that we are considering at this time, or is it too late, or what is going to happen in the meantime? That is to address the 1994 issue. And finally,

(3) If we do nothing, if we absolutely do nothing about this formula, where we will be in rural health care in the United States say in the next five years?

Thank you very much.

[The answers to Senator Pryor's three questions appear in the appendix.]

The CHAIRMAN. Thank you.

Senator Rockefeller.

Senator ROCKEFELLER. Mr. Chairman, just one quickie to Paul.

ProPAC indicated, in their survey of hospitals that had closed, that half the administrators said that PPS had nothing to do with it. Could you comment on that?

Mr. RETTIG. I don't know if I can comment definitively, but surely Medicare and PPS are extremely important to rural institutions. And if it is part of a larger picture of financial pressure, Medicare surely is significant.

I think we would want to support the kind of study program that ProPAC has outlined, to understand better what are the causes of the closures, what is driving them, in detail, so we understand them better, as well as some of the other things they wanted to look at—that is, to look realistically at what this really means in terms of access, and so forth.

Senator ROCKEFELLER. Do you have some of your own data at AHA?

Mr. RETTIG. I will provide whatever data I have. I am not prepared at the moment.

[The data appears in the appendix.]

Senator ROCKEFELLER. Thank you, Mr. Chairman.

The CHAIRMAN. Some comments have been made about costs and trying to get to one standard of payment, which we are trying to do in this particular piece of legislation. I heard one comment about $100 million of cost. That is not what we are speaking of in this piece of legislation; we are not talking about bringing down the compensation of the urban hospitals. They have their full share of problems. What we are talking about is something that is going to cost more on the order of $750 million. So we are talking about a sizeable amount of money. That is one of the problems in trying to accelerate it and expedite it, in bringing about the objective that we are trying to achieve.

Thank you very much, gentlemen. I know there are other questions that the members want to ask of you. I ask that they be reserved for writing, and that you respond to them.

[The questions appear in the appendix.]

The CHAIRMAN. Thank you.

Our next panel is: Dr. Michael McKinney, Family Practitioner, and Texas State Representative, District 15, testifying on behalf of the Texas Hospital Association, from Chester, Montana; Mr. Richard Brown, Administrator of Liberty County Hospital, and Chairman of the Montana Hospital Association, Mr. Robert Harman, the Administrator of the Grant Memorial Hospital, from Petersburg, West Virginia; and Mr. Eric Buckland, the Administrator of the North Lincoln Hospital, from Lincoln City, Oregon.

Would you please come forward, gentlemen?

[Pause.]

The CHAIRMAN. Dr. McKinney, if you would, lead off. We are very pleased to have you and are looking forward to your comments.

STATEMENT OF DR. MICHAEL D. McKINNEY, FAMILY PRACTITIONER, AND TEXAS STATE REPRESENTATIVE, DISTRICT 15, TESTIFYING ON BEHALF OF THE TEXAS HOSPITAL ASSOCIATION, CENTERVILLE, TX, ACCOMPANIED BY TOM NANCE, HOSPITAL ADMINISTRATOR

Dr. MCKINNEY. Thank you, Mr. Chairman.

I am Mike McKinney. I am not only a family practitioner, I am also a State Representative in Texas, and also one of those that had the distinct privilege of having legally voted for you twice last election. [Laughter.]

The CHAIRMAN. Only in Texas. [Laughter.]

Dr. MCKINNEY. That is right.

I also have with me Mr. Tom Nance, who is a hospital administrator in Atlanta, Texas.

I live in Centerville, which is in Leon County. I would have brought my own hospital administrator, except he is out looking for a job. Three weeks ago, we were the latest hospital to close in Texas. We now have 54 counties—54 counties in Texas, with no hospital. We have 93 counties in Texas with no hospital-based obstetrical care. I heard the numbers earlier on, but we have a population of 3.3 million, a rural population larger than some 23 total States. So the problem is very real.

I don't need to explain the problems to you; you all explained them to us very well, and I appreciate that. What I am going to tell you is that in Texas we didn't wait. We have been waiting since 1984 for some changes, and we have seen the profit in rural hospitals in Texas go from 8 percent to 3 percent. Last year, in the red, the rural hospitals were 10 percent—10.5 percent, as a matter of fact—and if we enact the budget cuts it will be 13 percent. That is a real significant number.

In Texas we didn't wait. We have started trying to grab ourselves by the bootstraps and come out of it. We passed a thing called the Omnibus Rural Health Care Rescue Act in the State Legislature. That is an attempt to address what we can address at a State level, understanding that it is our responsibility, too.

We tried to provide some regulatory relief that you have been asked for. We established some scholarship programs, understanding what the panelists said earlier, "You can't run a hospital if you don't have the doctors." So, we have established a scholarship program.

We have established ways to get family practice residencies in rural areas. They talked about not having medical school expenses or education expenses in rural areas. We are going to try to rotate our third-year medical students through the rural area. It is nice to convince them that, truthfully, at home I am "Dr. Mike," I am not "Dr. McKinney." And there is a whole lot to be said for that. But unless you can expose the students to that, they never understand it. So, we have started that.

We changed the standard dollar amount, in relation to Medicaid. We raised that to $1,600. I put a little rider in the Appropriations Bill that we are now in conference on, but I am convinced that rider will stay, which says, on the State Medicaid system, "All hospitals of 100 bed or less will be reimbursed on a TEFRA-based cost-based system," recognizing what has been told to you time and time again, that the statistics do not hold for the small hospitals, understanding that they do have a mission—that we don't do transplants, and we don't do heart surgery, but we do keep people alive when they have wrecks on the highway.

We also made some changes in relation to liability law. It turns out that that is a big part of it. If you are the only doc in the whole county when somebody shows up at the emergency room with a wreck, you are the neurosurgeon, and the chest surgeon, and if you are having a baby, you happen to be the obstetrician. There are some real liability problems, and we are trying to address that.

We also are doing what Texas has needed to do for a number of years, and that is, we are expanding our Medicaid program. Already we have passed an extension of the nursing home cap, to the federally-allowed maximum.

We have a program to expand Medicaid coverage to include the two-parent families, to bring in the children, in a State-funded program, even up to 130 percent of poverty. We are spending a great deal more money on our Medicaid recipients.

But what we found out, with a rural task force that we had for the last year and a half, was that it doesn't matter how many people you bring into the system. If there are more recipients and there are not enough providers, the truth is, you are not taking care of the people.

That is what we have had to address. We found that, indeed, the State was part of the problem, and we are trying to do that. And we found out that an inadequate or unfair Medicare reimbursement is certainly part of the problem.

We are not asking to be treated special. We are not asking that you identify rural areas and given them more. We just want to be treated fairly. We want to be treated the same.

I think that most of you having the rural areas know that is kind of the way people are in the country. I live out there because I like it. I don't want to have to get old and move to town. Used to be, you would be born on a farm and move to town to make a living, then for 40 years be trying to get back to the farm. Nowadays you have to move to town early, and you have to stay there, because the hospitals are closing.

With that, I will close.

[Dr. McKinney's prepared statement appears in the appendix.]

The CHAIRMAN. Doctor, you talk my kind of language. I have been pushing hard on this side on Medicaid, and you have been pushing hard from down home. We sure don't do enough in the way of Medicaid assistance. I am just delighted with the courage and the energy that you have dedicated to it. I am very pleased to have you here.

Mr. Brown, if you would, proceed, please.

STATEMENT OF RICHARD O. BROWN, ADMINISTRATOR, LIBERTY COUNTY HOSPITAL, AND CHAIRMAN, MONTANA HOSPITAL ASSOCIATION, CHESTER, MT, ACCOMPANIED BY TONY WELLEVER, VICE PRESIDENT, MONTANA HOSPITAL ASSOCIATION

Mr. BROWN. Mr. Chairman, Members of the Committee:

I am Richard Brown. I am the administrator at Liberty County Hospital in Chester, Montana. I am also serving this year as Chairman of the Montana Hospital Association. Accompanying me is Tony Wellever, who is the Vice President of the Montana Hospital Association. I would like to thank you for this opportunity to testify.

Providing health care in Montana is different from most other parts of the United States.

First, there is the population density. Montana is about the same size as Japan, but Japan has 150 times more people living in it. There is map over on my left indicating 22 counties which have two or fewer people per square mile. These are indicated in the yellow. Fifteen counties have a population density of between two and four people per square mile—those are colored in pink—and only seven counties, those in the green, have a population density of between four and six per square mile. In Japan, on the other hand, the population density is 825 per square mile.

Second, there is the distance between towns. My town, Chester, is located 30 miles south of the Canadian border. There are about 2400 people living in Liberty County. My hospital has 11 hospital beds in it; it is one of the smallest in the nation. The nearest hospital is 45 miles from Chester. The closest hospital with more than 100 beds is almost 100 miles away in Great Falls.

Overall, there are 65 hospitals in Montana. Most are small. Half have fewer than 30 beds, and a third have fewer than 20 beds. All but four are classified as rural. None of these hospitals are prosperous. The average net profit margin in 1987 for those with fewer than 30 beds was a negative 15.2 percent. True, these statistics apply only to Montana. But even though some of the numbers change, the stories are the same all across rural America.

The problems facing rural hospitals clearly existed before the Prospective Payment System was begun; but PPS has exacerbated these problems. However, just blaming PPS is too easy. Equally important are the dramatic changes that have irreversibly altered rural communities in recent years.

Hospitals are part of an economy that is interconnected and interdependent. In Montana and elsewhere, agriculture, timber, mining, and oil and gas are all struggling. As jobs are lost and income falls, families move on to look for new opportunities, and hospitals that were once thriving parts of the community teeter on the brink of closure.

Our world is vastly different than it was 20 years ago; however, our challenge is still the same—that is, to provide high quality and affordable health care. But how we meet this challenge has also changed. The hospital as we have traditionally known it is no longer viable. In today's environment of higher costs, fewer patients, and diminished resources, we know that we must find new and innovative ways to provide health care.

My hospital is involved in the search for these new methods of delivering health care. We are participating in three such projects: the Affordable Rural Coalition for Health, the Northern Montana Health Care Alliance, and a demonstration Medical Assistance Facility. We believe projects like these can provide models for the delivery of health care that can be used in other parts of the nation.

The ARCH project, the Affordable Rural Coalition for Health, is helping communities in a five-county area design a rural health care network. It is funded by the W. K. Kellogg Foundation. The ARCh five counties is outlined on yellow on the map.

A single principle has guided our work: small rural hospitals must move away from not only providing acute care services; instead, they must become health care centers. They must realize that one of the keys to their survival lies in providing a diversity of services.

The Northern Montana Health Care Alliance is funded by the Robert Wood Johnson Foundation and is administered by the Montana Hospital Research and Education Foundation. The Alliance is a cooperative effort of six hospitals and the health services of two

Indian reservations. It serves six counties roughly the size of New Hampshire and Vermont combined, and on the map they are outlined in pink.

We are focusing our efforts on four problem areas that require particularly innovative solutions.

First, we are addressing the crisis in obstetrical care in our State. As you can see on this map, in Montana, 18 of the 56 counties are currently without obstetrical services. We looked into that this morning and found another one that is without services. Eleven hospitals have stopped providing this care in the past two years because of the high malpractice insurance rates, which have forced their doctors to stop delivering babies.

Second, we are starting a shared service program, to expand access to services that individual hospitals cannot provide.

Third, we want to bring the college to the community for registered nurses, and we want to broaden the pool of available allied health professionals by providing multi-competency training.

Finally, we want to teach each community to be its own physician recruiter.

Liberty Council Hospital is also part of the HCFA demonstration project to test the viability of Medical Assistance Facilities. Medical Assistance Facilities are an innovative way to provide health care to areas that no longer can support a traditional hospital. An MAF is a limited-service rural hospital that provides inpatient care to ill or injured persons for not more than 96 hours. They can only be located in rural communities. They have unique licensing requirements, and they make greater use of physicians' assistants and nurse practitioners.

One hurdle stands in our way: The Office of Management and Budget must grant a waiver that will permit Medicare to reimburse these facilities for the care that they are providing to senior citizens. We welcome this committee's assistance in helping to clear that final hurdle.

Despite the effective advocacy of our plight by the public officials such as Senator Baucus in the past, we feel we have largely been ignored. The health care problems facing Manhattan, Montana, are vastly different from those facing Manhattan in New York City; but, too often, policymakers have failed to recognize these differences.

We in Montana welcome the attention given to the problems facing rural hospitals today. We welcome the legislation sponsored by Senators Bentsen and Dole to remove the rural-urban differential in payments. We also endorse Senator Baucus's bill to expand the number of sole community provider hospitals. We urge the committee to take action on this measure as soon as possible.

We also urge the committee to support projects that encourage the development of innovative ways for delivering health care in rural America. We believe that finding new solutions to old problems is the only way in which we can continue to guarantee that all Americans have access to high quality affordable health care.

Thank you.

[Mr. Brown's prepared statement appears in the appendix.]

Senator BAUCUS. Thank you very much, Dick.

Next, Mr. Harman.

STATEMENT OF ROBERT L. HARMAN, ADMINISTRATOR, GRANT MEMORIAL HOSPITAL, PETERSBURG, WV

Mr. HARMAN. Thank you, Senator, Members of the Committee: I am Robert L. Harman. I am the Administrator of Grant Memorial Hospital in Petersburg, West Virginia. I am also Chairman of the West Virginia Hospital Association Committee for Small and Rural Hospitals, and am currently serving as Chairman of the American Hospital Association's Governing Council for Small and Rural Hospitals. I appreciate the opportunity to be with you here today and discuss some of the problems of the rural facilities. Some of my comments may be repetitious, and for this I do apologize.

Currently, in West Virginia there are 62 hospitals of which 30 are small or rural. In 1987, there were five hospitals in West Virginia that closed that were small and rural. Currently, there are five or six additional hospitals that are suffering a severe financial crisis, and there is great concern about their continued viability.

I am encouraged to see the heightened concern and recognition of the problems, that the Medicare system has placed on rural facilities, by the committee. I am also encouraged to see that your recognition is there of the problem with the urban-rural differential, and that it is one of the major reasons why hospitals are facing severe financial difficulties.

In 1987, West Virginia had 35 small and rural hospitals. Twenty-two of these 35 hospitals had lost money from operations that averaged $404,000 per hospital.

The West Virginia Health Care Cost Review Authority has recently released a study of the Medicare margins for 1987. Of the 31 small or rural hospitals for which data was available, 20 had negative Medicare margins, with a total Medicare loss of almost $7.5 million, averaging roughly $371,000 per hospital.

Now, we know that a one-year operating loss doesn't really create a financial crisis; however, West Virginia's small and rural hospitals have been experiencing losses since 1984, the first year of the PPS system. This is more vividly depicted in the information that I have made available in the printed testimony.

In other testimony before Congress, we have seen that it has been projected that Medicare payments to hospitals in this coming year will fall short of their cost by 8 or 9 percent, and also that nearly two-thirds of all hospitals will lose money caring for Medicare patients.

We have heard the argument that hospitals nationally, and particularly rural hospitals, are losing money, but that Medicare's reimbursement policies aren't particularly the problem. Obviously there are other problems, such as your local economies that are declining, increasing indigent-care burdens, inadequate Medicaid reimbursement, and the increasing cost of technology. But again, as we have seen in the testimony this morning, the urban-rural differential is a leading factor. It cannot be singled out as the sole cause of the closures, but it is the major problem.

It is hard to see any improvement in the financial condition of rural hospitals without the provision of an equitable and adequate Medicare reimbursement policy.

As we have also seen this morning, there is an increasingly augmenting concern about accessing quality care in rural areas, should closures continue. From newborn obstetrical care to long-term care services, the rural health care delivery system is meeting a demonstrated need in our country.

Now, as the demand for services increases, as it surely will in the years to come, and as the pressure to reduce reimbursement levels grows, as it surely will, the ability to access health care services is going to become more acute. In my printed testimony, I give you an example of how this can occur in my own service area.

To whom does a patient turn when the local provider of care is no longer available? Are we approaching the acceptance of solutions such as those that are being debated in the Oregon Legislature, or a priority system for providing health care services to Medicaid patients? This is a form of rationing care to that particular section of our society that is less affluent.

As we have also seen, rural hospitals are taking a very active role in trying to adjust to and accommodate for the new environment that we find ourselves in. They are diversifying their services, and they are attempting to become a rural health center.

At Grant Memorial Hospital, we have selected various diversification opportunities to better serve our community. These include but are not limited to family-centered maternity care, skilled care, swing beds, respite care, home health care, homemaker services, hospice care, outpatient surgery, and outpatient orthopedic and podiatry clinics.

Diversity is a viable option for many rural facilities. Each facility and the community which it serves must determine the services that it needs and those services which can be provided through the local provider.

Experience has taught us that the hospital can be a key player in coordinating many of these community-oriented services and, in the process, maintain its viability. In this respect, I am pleased to hear that you are continuing your support for the Rural Health Transition Grant Program. This will provide the rural facilities an additional opportunity to demonstrate innovative approaches in providing health care services.

In summary, I believe that legislative support can make a difference in the current situation. Your support for the elimination of the urban-rural differential, adequate funding for the Medicare program, continued support for the Rural Health Transition Grant Program, the elimination of barriers to diversification, and support for ensuring access to care is a vital step towards ensuring the continued viability of our rural health care delivery system. Failure to address these issues will surely result in additional hospital closures nationally, and very assuredly in West Virginia.

Again, I appreciate the opportunity to be with you this morning. I will continue to work with you in ensuring accessibility for rural health care.

[Mr. Harman's prepared statement appears in the appendix.]

Senator BAUCUS. Thank you, Mr. Harman.

Mr. Buckland, you are batting clean up here. [Laughter.]

STATEMENT OF ERIC V. BUCKLAND, ADMINISTRATOR, NORTH LINCOLN HOSPITAL, LINCOLN CITY, OR

Mr. BUCKLAND. Thank you, Senator, and Members of the Committee, for providing me the opportunity to share with you some of the strategies we have developed to ensure our survival in the midst of such threatening change.

You have already heard testimony stating the current financial crisis experienced by so many hospitals in rural America. And although North Lincoln Hospital is subject to these same financial constraints, I am not here to enumerate our difficulties but rather to share our hope.

My name is Eric Buckland, and I am the administrator of North Lincoln Hospital, serving the northern half of Lincoln County, on the central Oregon coast. Before discussing some of the strategies we are pursuing, perhaps a description of Lincoln County would be helpful.

Lincoln County covers an area of approximately 990 square miles, bordered most prominently by the Pacific Ocean. The county's population of 37,000 is clustered principally in small coastal towns, of which Lincoln City and Newport are largest, with populations of 6,000 and 8300 respectively. Our moderate climate has rendered Lincoln County a popular retirement area, with 20 percent of our population exceeding the age of 65, 28 percent exceeding the age of 60.

Until March 1985, three hospitals served Lincoln County: North Lincoln Hospital, New Lincoln Hospital, and Pacific Communities Hospital. Due primarily to large indigent Medicaid and Medicare populations, New Lincoln Hospital was unable to remain financially viable and closed its doors in March of 1985. North Lincoln Hospital, located in Lincoln City, is approximately 30 miles north of Pacific Communities Hospital, located in Newport.

North Lincoln and Pacific Communities Hospitals have 49 and 46 licensed beds, respectively, and both provide a similar array of inpatient and outpatient services. Both facilities are Health District Hospitals, with a limited tax base. Revenues from property taxes account for approximately 6 percent of total revenues for each facility.

Although tax revenues were historically restricted for facility and equipment replacement, since 1986 tax revenues have been required to offset operating losses incurred by both facilities.

The threat of imminent closure became very real to us when we saw New Lincoln Hospital succumb to financial pressures and close its doors in 1985. It was in recognition of such financial realities that the North Lincoln and Pacific Communities Hospitals perceived the need to form an alliance to study common problems and identify common goals and solutions. The governing boards of both hospitals began holding exploratory meetings in early 1988.

This alliance has already produced a substantial number of cost-saving measures, which we have already implemented, including the sharing of medical technicians, formation of a nursing relief pool, formation of a joint legislative action committee, the joint purchase of equipment, the sharing of costs associated with the management training program, and sharing of expenses incurred in recruitment of a urologist to serve both health districts.

Our joint problem-solving has, to date, defined the primary problem facing most rural problems as a problem of productivity. Simply stated, declines in our inpatient census have inhibited the productive use of our assets. For most rural hospitals, the development of outpatient programs has not generated sufficient revenues to offset the costs of providing inpatient care. Therefore, in our opinion, survival will require rural hospitals to identify ways to leverage more effectively our relatively fixed-asset base.

To this end, our consortium has identified three primary means to enhance the productivity of our assets.

First, we recognize the need to improve our operating efficiencies, by reclaiming, where possible, economies attendant to higher patient volumes—or, stated another way, to reduce any operating inefficiencies attendant with reduced inpatient utilization.

Second, we recognize that traditional planning processes are ineffective in facilitating our adaptation to the rapid changes that we are experiencing. Thus, a new pro-active participant approach geared to the small hospital environment is necessary.

Finally, we recognize that we must leverage the one resource with unlimited potential, our people. In order to leverage our human resources effectively, we recognize the need to alter our structures, policies, procedures, processes, to capitalize on this unlimited resource.

The strategies to accomplish the above-stated objectives include:

—The formation of a joint management and support services corporation to reduce duplication of administrative, clinical management, and educational functions, and to facilitate the re-attainment of economies of scale; and

—The restructuring of management and planning structures, processes, policies, and procedures, to leverage more effectively our human resources.

In order to realize the potential of our most critical resource, people, our planning and management processes will be restructured to solicit the participation of all of our personnel in the planning and achievement of a desired future. This objective will be accomplished by providing all of our staff with requisite training, and through a restructuring of our planning processes.

Additionally, an "innovation fund" has been created and is being maintained, by philanthropic donations, to provide the resources for individuals within our organizations to pursue innovative ideas.

Finally, we are in the process of developing an incentive-based compensation system to further encourage participation, and to serve as a model for small rural hospitals.

We recognize that much of what we are doing is not new. However, the application of these principles in a rural hospital may enable Lincoln County, Oregon, to continue to receive accessible, high quality health care in an era of fiscal constraints.

In summary, we believe that rural hospitals have responded to the cost-containment mandate. We also believe that further gains can be achieved only through such cooperative endeavors.

However, further cuts in Medicare funding for rural hospitals most certainly will imperil the quality of care we are able to provide to our elderly Medicare beneficiaries, at the least; and at worst, it will eliminate access to health care, due to further hospital closures.

Thank you for providing me with this opportunity to contribute my view on this vital national issue.

[Mr. Buckland's prepared statement appears in the appendix.]

Senator **Baucus**. Thank you all very much. It is clear that all of you, as administrators, and others, have been scrapping and scrapping to stay alive. That is, you have become very, very efficient. In fact, you have done about all that can be done. You are very resourceful, very creative. You have tried to find ways to stay alive and have tried to find ways to continue to provide service. It is clear you have done a lot, certainly much more than large urban hospitals have. It is also clear that you have gone about as far as you can go; that is, without some assistance, some relief here, you will just not be able to provide the health care that communities in rural America need.

Dick, I wonder if you can describe and explain a bit about Medical Assistance Facilities, and the role of Medical Assistance Facilities in rural America. Where do you think that will fit, and how do we get there, and what do we have to do to make that happen?

Mr. **Brown**. I think the role that we are expecting out of the pilot program is that it will not be the answer to all communities who may lose their rural hospital. There is a chance that we may be able to provide a different type of hospital setting in a small community.

Senator **Baucus**. In the most remote parts?

Mr. **Brown**. In the more remote communities. And by that, it will be an easing of the regulations regarding staffing, and I think the limitations on the services will be based on the resources available within the hospitals. If they don't have a physician, they can use a physicians' assistants. That will limit the types of services they can provide.

But, again, I think the goal is to maintain a level of health care in communities. If you lose total health care in a community that is already 45 minutes away from another hospital, and then your neighbor closes, and now you are maybe 100 miles away from a hospital, you have just eliminated the access for a lot of people.

Again, one of the hurdles that I mentioned earlier was the Medicare waiver, because in the rural hospitals we tend to have 60 to 70 percent of our patients that are Medicare, and if we cannot get a Medicare waiver for payment to an MAF, we can't make it; there is no reimbursement program for that. So, we need that waiver. I think that is one of the bigger hurdles right now, and if that can be overcome, it will help this project along the way.

Senator **Baucus**. In our State, two out of three hospitals that closed, closed in part because physicians left the communities. Could you just very briefly tell us what we need to do to help give sufficient incentives to rural docs to stay in rural areas, or to go to rural areas? Because, obviously, a hospital without a doctor is not going to provide any service.

Mr. **Brown**. That is right.

A couple of things come to mind. I think the first that would have a big impact in the rural hospitals is the continuation and full support of the National Health Service Corps Program, in which physicians pay back an obligation to the Government for their paying for their education by serving two to three to four years in rural communities as the major health care provider. We have been members of that program for 15 years, and it has been a large part of our salvation. There are several communities in Montana that I know in the northwest that utilize doctors in the National Health Service Corps Program. We need to continue to support that.

Senator BAUCUS. Is that sufficient, though? Do we also have to provide doctors with, say, additional 5 or 10 percent reimbursement under Medicare as rural docs?

Mr. BROWN. Yes. I think the corps program is only a part of it. The other is the reimbursement. Again, physicians in rural areas right now, similar to hospitals, are physicians who are receiving less reimbursement than their urban counterparts. There is not the incentive, then, to move to rural Montana or Wyoming to become a private practitioner. Most of our communities have one or two physicians, and you need a lot of incentives to keep one or two doctors working in a community.

Senator BAUCUS. I would like to have any of you respond to any comments that Mr. Erickson made, the member of ProPAC. Did he say anything that you would like to amplify, or question, or whatever? Any of you.

Mr. Nance.

Mr. NANCE. Cost, to me, is defined as what I pay for something, not what I charge for it. Twenty-five miles away in the urban hospital, they pay the same price for a pill that I pay. We get reimbursed less. Their nurses can get more, because they get reimbursed more. Our wage index is .7623, which means that we are supposed to get .7623 of what somebody else somewhere gets.

Not wanting to step on any kind of area that may not be wanted to be talked about, but if the minimum wage is passed, can we pay our people .7623 of the minimum wage? No. We don't have anybody that low already. But we would have to pay them the full minimum wage, if we had anyone.

The weight factor that is involved can be changed per serious illness. Of 448 patients that we had in an 8-month period last year, 101 DRGs were utilized, and 49 of those only had one patient. Eleven DRGs had 10 to 40 patients; 231 were in that 11 DRGs.

Just to take one DRG, DRG-89, which is pneumonia, and compare it, as I have done, with an urban hospital 25 miles away, and if I and waited 30 days for my comparison until they got their increase, while we did not get ours—we have to wait, because our fiscal years are different— for the first eight months of 1988, for DRG-89, they got $577.49 more per patient. Thirty days later that was increased to where they got $1138.60 more per patient. I have to pay my nurses, laboratory technicians, and everyone else what they receive, in order to keep them.

One-third of the closures has been in Texas hospitals.

Senator BAUCUS. Thank you very much.

Senator Durenberger?

Senator DURENBERGER. Yes, Mr. Chairman.

I don't known if anybody else wanted to respond. Mr. Erickson stayed around for it, and perhaps our doctor-legislator might want to add a response to Max's question, as well.

Dr. McKinney. I will always add to that. I think that probably a statement was made that was right: I think we need both more and better representation on that board. I think that is right.

I will speak to the 12 percent that they can't account for. I understand the political problems of cutting into somebody else, if it is a zero-sum gain. But the bottom line is, if it is not right, it is just not right. And if they can't account for the 12 percent, I don't think you can justify a 12-percent penalty just because it was built in last year.

Now, I understand the political part of it; I have had to do those, too. But it is not reasonable. Even if it is a zero-sum gain, and truthfully, even if it comes out of the urban hospitals, fair is fair, and that is all we are asking for.

Senator Durenberger. Thank you.

I know what you meant by "better." You meant, you know, sort of broadening the impact that it has, and that is no reflection on Mr. Erickson at all.

Dr. McKinney. No.

Senator Durenberger. Because all of us have struggled to get one person on each of these committees or commissions around here, whether the OTA is doing it or somebody else is doing it. And you know, when you are getting that one person on there, that after they have been there for a little while they are going to be overwhelmed by the bureaucracy loading all of this data on them, coming out of these very expensive computers, and then they say to you, "You know, figures can't lie," and all of that sort of thing. They beat you over the head with this large amount, this huge volume, of data that gets to be so hard to argue with. And I will bet he sits there like my hospital administrators, and Mr. Nance, and all of the rest of you guys, saying, "Well, I know my case is different; maybe the rest of the country is different," but he doesn't get to go around the rest of the country.

One of the advantages of sitting here is, I can tell you—you know, I have been out to Montana. I haven't been to Texas, it is too big. It is too big a challenge. But I have to Montana, and I have been around quite a few of these little hospitals, and they are not any different. I mean, nothing I have heard here is any different from what I have heard in Minnesota; but then, I don't have to go to these meetings that Mr. Erickson goes to and be overwhelmed by all of this aggregated data. You and I have the luxury of dealing with the reality as we see it and hear it and feel it, and that sort of thing.

But one of the questions that Bob Packwood wanted proposed to Mr. Buckland, I think we can just expand on. Mr. Nance said he pays the same thing for a pill as the urban hospitals pay. I will bet you he doesn't. I will bet you pay more, because they have got such high volume, unless you belong to VHA or you have got some kind of purchasing mechanism. But the reality is, whether it is a pill or a bandage, or whatever it is, you have the problem of the law of large numbers working for against you all of the time, and so the pill costs less in the cities—and they are getting a lot more of it freebie, too, I would imagine, than you do in the rural area.

But whether it is that, or it is getting something fixed -how many miles do you have to go to get some very complicated thing fixed, and how long do you have to wait for it to get back, compared to the big cities?

Bob wants me to ask about are rural hospitals subject to the same licensing and accreditation standards as urban hospitals. And add to that the dimension we haven't talked about here today, of the weight of administration—the PPS and the Peer Review, and the intermediary, and you add all of the necessity and appropriateness, and all of those other wonderful things we add into the law—the weight of that administration on a small hospital versus a large hospital.

Maybe you want to comment on that, Mr. Buckland.

Mr. BUCKLAND. Yes, I would like to. I think that is one of the frustrations that confronts all rural hospital administrators and administrative people, and that is that the larger urban hospitals have the luxury—and I will use that term for the time being—of being strictly administratively-focused people. They are not working managers, in the sense that they are not providing direct patient care.

The problem that working managers are confronted with on a daily basis is, when do you find time, when you have patients knocking at your door, to take care of the planning, the leadership, doing some of the more prudent purchasing types of activities that you have mentioned? Those are very time-consuming tasks. We don't have the administrative structure frequently to support that.

Senator DURENBERGER. I am going to quit here, so Jay can ask questions, or so we can leave. But I talked earlier about the doctors, and then I talked about the nurses, and we haven't come back to this nursing situation yet.

Maybe I am only experiencing it in Minnesota and it isn't happening around the rest of the country; but having been around with the National Commission that Carolyn Davis is chairing, and then watching the competition in the small towns, with the VA hospital that you have got to compete with for nurses, and I imagine in Texas and Montana you have got all of these government bases, you know, and they have got a different capacity to offer salaries than you do in your small hospitals, all the competition, including right in your community for the nursing homes and all the rest of that sort of thing, for the professional, that is probably the best bargain, if you are looking to find good ways to deliver medical care.

Am I right when I say that nobody in this country, other than the folks that run hospitals, really has appreciated this big ticket that is coming down the pike for us, as the nursing profession and allied health services, finally, in this tight labor market, get paid what they believe, and I think a lot of the rest of us believe, we ought to be paying them? And that is another huge big ticket coming down the pike. Am I not correct on that?

Mr. BROWN. I think that is correct. And you are right, it is not just going to be the nursing profession; we are looking at all technicians and technologists. We are seeing that in Montana already.

The competition that we have is with the cities 100 miles away, we don't get the applications for these jobs.

I was talking to a friend last week whose wife had made an application at the hospital in Great Falls. They called and offered her whatever position she wanted, at whatever salary—"We will negotiate it," and she is going to jump right on it. I don't even get the application on my desk.

We have been looking for about six months for a lab technician. Most of those who are interested want about $15,000 more a year than I am paying my top people. We cannot compete at those rates, and it is going to get a lot worse.

Mr. **Harman**. I think this is absolutely true, and you are going to see this exacerbate itself, because as these technicians and professional people are able to draw down these higher salaries, and we have to compete for them, costs in our areas are going to go up. It is a direct result, and it is a have-to case.

When you are comparing the urban and the rural situations, as was indicated here, in dealing with the PRO, utilization review, and all these other things, you have working managers who are taking care of patients, doing the everyday work, and on top of that trying to do utilization review and all of the other aspects of regulation; whereas, in an urban facility there are specific people to do this.

If this increases, if the pressure increases on the regulatory side to perform these functions, then you have to add people to do this—again, increasing costs, for which we have to get reimbursed, or we won't survive.

Senator **Durenberger**. Mr. Rettig, before he was at the American Hospital Association, was at the Mayo Clinic. And the Mayo Clinic used to advertise in all of the small towns. You know, "Why work overtime at your hospital" in your small town. "Why don't you come into the Mayo Clinic? We will pay you $25 an hour," or something like that, "to come to the Mayo Clinic in your spare time." This whole phenomenon now of the nursing pool is also helping to raise the cost to everybody, is it not?

Mr. **Buckland**. I just want to add one other comment. You alluded to "the future does not look much better." I think I would reinforce your projections. That is, if you look at the programs both for nursing as well as some of the radiology technologists, and some of these other positions, those entering the programs are insufficient to supply our needs, and that is going to remain the case for many years to come.

So, this situation is only going to become exacerbated. And again, to the degree that we are competing in a State-wide labor market or a nation-wide labor market for almost all forms of clinical personnel, I don't know where the differential comes into play, to be honest with you.

Senator **Durenberger**. Mr. Nance?

Mr. **Nance**. Senator, at the first of your questions, you asked if we had to meet the same conditions of participation, and we do. The difference is that the same size survey team comes in my hospital that will go into a 400-bed hospital. They will spend the same two and a half to three days in my hospital as a large hospital. They cannot get around and see as much of the large hospital in that same timeframe as they can in my hospital. They will look at the same number of records, 100 records. That is a larger percentage of my total number of records.

The other thing that I would urge of any legislative action: Before it is made part of the rule, the regulation, the law, consider the impact on the hospital. We consider, in the aggregate, the impact on the budget of the United States. We do not consider—legislatively, rulemaking, or anything of that kind—the effect on the hospital. And I think that is very important.

One other little, quick thing. In my town, a doctor gets $17 for a Medicare visit. Twenty-five miles away they get $37 for a visit. And now we have 2490 people per physician in our county, and the average rurals across the United States is 1260.

Senator ROCKEFELLER. Just a final question, and I will direct this to Bob Harman, from my own State:

Do rural hospitals generally regard rural health clinics as competition, or as part of a common approach to rural health care?

Mr. HARMAN. Speaking specifically for West Virginia, I think the situation there is that the rural health clinic is seen as part of a partnership.

One aspect of this particular program that is coming into play at this point is, it is being looked at by rural hospitals as a part of their program for providing care, bringing a rural health clinic setting into the rural hospital.

Senator ROCKEFELLER. Do you mean by making them one and the same?

Mr. HARMAN. Yes. I think this has already been done, at least in one institution in Kansas, and I know in West Virginia there are at least three hospitals who are looking at that possibility, who have the physician assistant or nurse practitioner available to them, that they can apply for a rural health clinic status for the hospital itself. And I think, from that perspective, it is viewed as part of the solution to the problem.

Senator ROCKEFELLER. Isn't it ironic, in a sense, that when the Rural Health Clinic Services Act was passed, it was based upon the lack of doctors, of physicians, back in the sixties and the seventies? And now, we are not only facing that, but we are also facing a lack of physicians' assistants and nurse practitioners. So, even with the rural health clinics—I am interested in this, because I have got some legislation; I want to try and get rid of some of the regulatory problems, one being, for example, that a nurse practitioner or a physician assistant, I believe, has to practice at least 60 percent of the time in a rural health clinic, in order for them to be certified and gain Medicaid/Medicare status. But often, because of the shortage, that nurse practitioner or physician assistant may, in fact, be serving two rural health clinics. My bill would allow nurse practitioners or physician assistants to be at a clinic 50 percent of the time the clinic is open.

So, it is interesting to me that hospitals and rural health clinics, each under duress, each trying to help in a rural setting, really do have to cooperate. Don't they? And when Congress passed this Act, it anticipated 2,000 rural health clinics to spring up across the country, and I think there have been about 400.

So rural hospitals and health clinics do in fact need each other, don't they?

Mr. **Harman**. I think that is absolutely true. I think you can see the perspective in Montana, when they are talking about doing the Medical Assistance Facilities out there, that you do need these ancillary people in order to make that kind of system work.

I think it is kind of axiomatic that this kind of situation has developed.

Senator **Rockefeller**. Just a final, final question:

Management seems to be really key to this, being innovative for rural hospitals. If you are not innovative, you are just not going to make it. And we can make all of the arguments that rural America has just exactly the same rights as does Manhattan, but if the formula says that you are destined to fail financially, then it doesn't make any difference whether American values or fairness is served or not; the hospital is going to disappear. So far 5 hospitals have closed in West Virginia.

So there is a tremendous premium—is there not?—on the management and the innovative ability of management in the rural hospital system to push out the day—another week, another month, another year—for survival for hospitals. I mean it has really come to that point, hasn't it? You cannot count on the formula at this point; you have got to count on offering new services and all kinds of things.

Mr. **Harman**. You have got to be very flexible. I think your observations are right on key.

You know, coming back to Mr. Erickson's question on what facilities are going to survive and what are not going to survive, I think it is crucial in this day and age, and I don't know who is going to draw that line and decide; but I think if you are a practicing administrator out there, you have to look at absolutely every opportunity that is there, and work with your community, and try to see that you do survive, if in fact you are needed there.

Senator **Rockefeller**. Can I also ask you if you, as rural hospital administrators—I don't mean you individually, but you generically—are also being competed for? In other words, that the more innovative you are and therefore the more you can do to save rural hospitals, the more you will be noticed, and therefore the less chance that you will be able to stay there, because somebody will come to you with an offer of twice the money, and you have kids that have to go to college, and you cannot say no?

Mr. **Harman**. I don't know, Senator.

Senator **Rockefeller**. Generically. Have you heard that discussed?

Mr. **Brown**. I believe that is true. If you are innovative and aggressive, and you are doing things with your facility, somebody out there who is not having that happen is going to want you.

Senator **Rockefeller**. Lots of problems.

Thank you, gentlemen, very, very much.

This hearing is closed.

[Whereupon, at 1:00 p.m., the hearing was concluded.]

APPENDIX

Alphabetical Listing and Material Submitted

Pepared Statement of Senator David L. Boren

The issue of health care is one of the most important issues that we will deal with in Congress this year. The quality and the affordability of health care are crucial to every one of our constituents. The need for assistance is particularly magnified in many areas of Oklahoma. More than half of the people in my State live in rural areas where adequate care is often miles away from a family's home, if available at all. It is hard to encourage physicians and health care professionals to locate in those areas, and especially difficult for many small hospitals that are losing money to recruit qualified, dedicated medical personnel. It has become quite a challenge for hospitals that serve these rural, often isolated areas to stay in business, much less to achieve the level of quality that they would like to offer.

Access to health care is not only a health issue. It is an economic issue. It is often the deciding factor of whether or not an area is attractive to new industry and economic development. For many rural areas in Oklahoma that are dependent on agriculture and energy, the beating they have taken over the last ten years has left them with barely an infrastructure left to survive.

I have joined with other members of the Senate to form a rural development task force in order to begin a new effort to meet the needs of rural America. We are seeing an emerging pattern of economic difficulty in rural communities that requires us to work together to assist in the recovery of these areas of our country. I honestly feel that by helping our rural hospitals survive to serve the people that need health care, we will be doing our States a tremendous service in many ways.

We cannot sit idly by and hope that these problems correct themselves. I am pleased that in recent weeks, a number of very important initiatives have emerged in Congress to address the crisis confronting rural hospitals around the country. I am especially pleased to note that the majority of the members of this committee are also members of the Senate Rural Health Caucus and have sponsored and cosponsored a host of bills already this year deliberately focusing on the special needs of rural hospitals. We need to carefully craft legislation this year that will make the best use of the limited funding that is available to us.

More and more people are becoming aware of the escalating number of hospital closings occurring in small communities which are extremely dependent on their local health care facilities. Since 1984, 159 hospitals have closed in rural areas across the country. Top analysts have predicted that as many as 600 hospitals could close their doors by 1994. While financial problems do confront urban hospitals as well, the economic viability is often dependent on these services in rural America.

I strongly support Chairman Bentsen's bill, S.306, to minimize the differential between Medicare reimbursements to rural and urban hospitals. I think it is a good sign that almost all the members of this committee are cosponsors of this bill. The sweeping changes that have occurred in Medicare in recent years have placed difficult demands on every part of the health care system, but most noticeably on these hospitals. We made some limited progress during the 100th Congress when a greater increase was granted to rural institutions in the PPS inflation update; still, there is much that needs to be done, and I intend to be a strong advocate of our rural hospitals as we in Congress continue to work on this issue.

I have also added my support to a number of other bills to assist rural hospitals, especially those who are rural referral centers and sole community providers. I want to thank those members of this committee who are so committed to helping rural hospitals and who have offered legislation addressing these needs. Rural hospitals comprise the backbone of the health care system for millions of Americans. In this time of crisis, we must do everything possible to rectify the unfair disadvantages built into the health care system and find ways to strengthen rural hospitals. I will continue to work with members of this committee and other members of the Senate to communicate the severity of this problem and make the decisions necessary to halt this damaging trend.

PREPARED STATEMENT OF RICHARD O. BROWN

Mr. Chairman, members of the Committee, I am Richard O. Brown. I am the administrator of the Liberty County Hospital in Chester, Montana. I am also serving this year as the chairman of the Montana Hospital Association.

Thank you for this opportunity to testify today and to discuss the problems that face providers of health care in rural America.

Health Care Delivery in Montana

Providing health care in Montana is different from most other parts of the United States. Yet, in many ways, the problems we face are faced by community hospitals in every part of the Nation.

One reason for the difference is our size and population density. Our State stretches over a 146,000 square mile area, an area roughly the size of Japan. In Japan, however, the population density is about 825 people per square mile. In Montana it is 5.6. The population of Japan is 150 times larger than that of Montana.

Towns are far apart in Montana, and communities isolated. For example, my town—Chester—is located 30 miles south of the Canadian border; it has a population of about 2,500 people.

The nearest hospital is 45 miles from Chester. The closest hospital with more than 100 beds is almost 100 miles away in Great Falls.

Liberty County Hospital has 11 beds, making it one of the smallest in the Nation. Were it not for the attached nursing home with its 40 beds, our hospital probably could not continue to provide health care services.

Overall, there are 65 hospitals in Montana. All but four are classified as rural, according to the definition provided by the Health Care Financing Administration. Of these, 51 have fewer than 89 beds, 32 have fewer than 30 beds and 23 have fewer than 20 beds.

None of these hospitals are prosperous. Of the 32 hospitals with fewer than 30 beds, 24 operated in the red in 1987. Their average net profit margin in 1987 was a −15.2 percent.

Health Care in Rural America

Our story is not unique. You will hear much today about the problems of rural hospitals in other areas.

Many of the problems we face are the direct result of the prospective payment system for Medicare.

But just blaming PPS is too easy and too simple. In Montana and other rural States, hospitals are part of the total economy, and the economic health of agriculture, mining, oil and gas and the timber industries plays a great role in the viability of a community hospital.

The changes occuring in rural America are well-documented. Family farms are disappearing, forced out of business by debt and drought and a sluggish market. Slumping oil and gas prices have brought a slowdown in exploration and production. Small town timber mills, technologically unable to compete, are closing or dramatically reducing the size of their workforce.

As a result, families are leaving Montana's communities and communities all over rural America. And hospitals that were once thriving parts of the community are now teetering on the brink of closure.

Small community hospitals today are characterized by high Medicare utilization, paid for at levels that do not adequately reflect the cost of treatment. This condition is worsened by chronic health manpower shortages and a regulatory environment geared toward an average hospital size of 150 beds.

But people still need doctors, and hospitals. People still get sick, people still have babies, they still have surgery and they still have accidents.

Even though our world is vastly different than it was 20 years ago, our challenge is still the same: to provide high quality and affordable health care. We in Montana are deeply committed to that goal.

But we in Montana also know that *how* we fulfill that goal has changed. The hospital, as we have traditionally known it, is no longer viable.

In today's environment of higher costs, fewer patients and diminished resources, we know that we must find new and innovative ways to provide health care.

My hospital is involved in the search for these new methods of delivering health care. We are participating in three such projects. We believe these projects can provide models for the delivery of health care that can be used in other parts of the Nation.

ARCH

One of the keys to the survival of rural hospitals lies in diversity. My community is involved in a project that is designed to do that for a five county area.

This project is called the Affordable Rural Coalition for Health, or ARCH. The coalition consists of five community hospitals; it is funded by the W.K. Kellogg Foundation and sponsored by the Lutheran Hospitals and Homes Society and the Center for Rural Health Services, Policy and Research.

The ARCH project is helping our communities design a regional health care network. We believe small rural hospitals must move away from being only providers of acute care services toward becoming health care centers.

Thus far we have focused on making sure our communities know what health care services are available throughout the ARCH area. Our next step is to develop area-wide sharing of resources.

Northern Montana Health Care Alliance

My hospital also participates in what's called the Northern Montana Health Care Alliance.

The Alliance is funded by the Robert Wood Johnson Foundation through its Hospital-Based Rural Hospital Program and is administered by the Montana Hospital Research and Education Foundation.

The Alliance is a cooperative effort of six hospitals and the health services of two Indian reservations, and serves a six-county area roughly the size of New Hampshire and Vermont combined.

The purpose of the Alliance is to improve health care services by improving cooperation between the hospitals in our region.

We are concentrating on four distinct areas: obstetrical risk management, shared services, continuing education and physician recruitment.

The lack of obstetrical services in rural Montana has reached crisis proportions. In 18 counties no obstetrical services are available. Eleven hospitals have stopped providing this service in the past two years because high malpractice insurance rates have forced their doctors to stop delivering babies. We are seeking new ways to provide access to these services.

By using a shared services program, we also want to increase the access to services that individual hospitals cannot provide.

And we want to improve the educational opportunities in our communities with a continuing education program. We want to bring the college to the community for registered nurses and we want to broaden the pool of available allied health professionals by providing multi-competency training. In other words, we want to teach technicians to be minimally proficient in more than one technical area.

Finally, the physician recruitment program is helping each community be its own physician recruiter, thus eliminating the need to employ expensive consultants for physician recruitment.

As we work on these four areas, we hope to create a service network among the coalition members that will continue beyond the life of the grant funding.

Medical Assistance Facility

Third, the Liberty County Hospital is part of a HCFA demonstration project to create a Medical Assistance Facility, a project that is attracting attention from all over the U.S.

Medical Assistance Facilities are a new concept in providing institutional health care services to remote and sparsely populated areas. The MAF concept formalizes the frontier health system for the first time.

They are not a scheme to keep open rural hospitals in danger of closing. Rather, they are an innovative way to provide health care to areas that no longer can support a traditional hospital.

An MAF is a health care facility that provides inpatient care to ill or injured persons for not more than 96 hours. MAF's can only be located in counties with fewer than six residents per square mile, or in communities that are at least 35 miles from the nearest hospital.

MAF's have unique licensing and certification requirements. The staffing requirements for registered nurses are eased, fewer ancillary services are required than are necessary in hospitals, and the physical plant standards are somewhat relaxed.

One of the most novel provisions of the certification rules for MAF's is the expanded use of mid-level practitioners—physician assistants and nurse practitioners.

An MAF is required to have at least one physician on its medical staff. However, mid-level practitioners are permitted to admit and, within the scope of their allowed practice, treat patients. All of the servics provided by mid-level practitioners are reviewed by the sponsoring physician.

MAF's do not replace physicians. But in communities that are unable to recruit and retain a physician, or in communities where there is a need for more than one medical practitioner but not for two, the use of mid-level practitioners increases the options for health care delivery.

MAF's must have a formal referral agreement with a hospital, a skilled nursing facility and a home health agency. It is also likely that MAF's will form relationships with primary care providers, and dental and mental health providers. And MAF's will provide vital triage services in rural areas.

The idea of a limited service rural hospital, which is what an MAF is, is not new. In 1974, Arthur D. Little, Inc., under contract to the Department of Health, Education and Welfare, created a new licensing category and tested it in 28 hospitals in seven States (Colorado, Georgia, Mississippi, Missouri, Oklahoma, Tennessee and Texas.)

In its conclusion, Little stated, "Doubts and reservations will combine to defeat the idea of LSR hospitals on a national scale. On the other hand, in States like Texas and Alaska, whose geographic extent creates a special need, rural hospitals play an important role in meeting the States' health care requirements. In these locales need furnishes the incentive to develop new kinds of providers, and on a statewide basis LSR hospitals could be developed."

Two years later, Senate Majority Leader Mike Mansfield, and his Montana colleagues, Senator Lee Metcalf, Congressman Max Baucus and Congressman John Melcher, sent a letter to then-Secretary of HEW Mathews asking him to implement the LSR hospital concept. Obviously the response was not positive. Fifteen years later, we are still discussing the same issue.

The idea of a downsized hospital had merit 15 years ago, and I believe it has merit today. And, by its support of our project, HCFA is indicating that it agrees.

We are nearing completion of phase one of the MAF project. Now we are seeking a waiver from the Office of Management and Budget that will permit Medicare to reimburse these facilities for the care they provide to senior citizens. We welcome your assistance in helping us clear this final hurdle.

Conclusion

We in Montana welcome the attention given these days to the problems facing rural hospitals. Despite the effective advocacy of our plight by public officials such as Senator Baucus, we have largely been ignored.

The health care problems facing Manhattan, Montana are vastly different from those facing Manhattan in New York City.

But too often the solutions from Congress have failed to recognize those differences. Too often those solutions have been geared to big city and urban hospitals. And too often we in small communities across America have suffered because of these solutions.

The problems facing rural hospitals clearly existed before PPS. But PPS has exacerbated those problems.

We welcome the legislation sponsored by Senator Bentsen and Senator Dole to remove the rural/urban differential in payments.

We also endorse Senator Baucus' bill to expand the number of sole community provider hospitals. We urge the Committee to take action on this legislation as soon as possible.

We also urge the Committee to look closely at the innovative ways being developed in rural America for delivering health care.

We believe finding new solutions to old problems is the only way we can continue to guarantee that all Americans have access to high quality affordable health care.

Thank you.

PREPARED STATEMENT OF ERIC BUCKLAND

Thank you, ladies and gentlemen, for providing me the opportunity to share with you some of the strategies we have developed in response to the declining revenue base created by the advent of the Medicare prospective payment system. I know you have heard much testimony regarding the current financial crisis experienced by so many rural hospitals in America. Although North Lincoln Hospital is subject to these same financial constraints, I am not here to enumerate our difficulties, but rather, to share our hope.

My name is Eric Buckland. I am the Administrator of North Lincoln Hospital, serving the northern half of Lincoln County, Oregon.

Before discussing some of the strategies we are pursuing in response to recent changes in the health care environment, perhaps a description of Lincoln County would be helpful.

Lincoln County covers an area of approximately 990 square miles bordered by about 50 miles of the Pacific Ocean. while extending inland 15–30 miles, the county's population of 36,900 (1986 est.) is clustered principally in small coastal towns of which Lincoln City and Newport are the largest with populations of 6,000 and 8,300, respectively. The Coastal Mountain Range extends almost the entire length of the county and, although we are no strangers to rain, the climate is moderate with a relatively narrow range of variation.

The coast's major revenue sources are tourism and a rapidly rising tide of retirees. Elderly Americans are attracted to the coast as their final residence site by its scenic grandeur, mild climate, and crime-free, casual lifestyle. For those of modest means, the coast's depressed housing market makes the environmental elegance affordable.

Consequently, Lincoln County has become a popular retirement area with 20% of our population exceeding the age of 65, 28% exceeding the age of 60, and over 45% exceeding the age of 45. Approximately 25% of the families within our county fall within the Federal poverty guidelines with incomes below $10,000 per annum. Fully 45% have annual incomes below $15,000. Of those under age 65, almost 20% are uninsured.

Until March, 1985, three hospitals served Lincoln County: North Lincoln Hospital, New Lincoln Hospital, and Pacific Communities Hospital. Due primarily to large indigent, Medicaid, and Medicare populations, New Lincoln Hospital was unable to remain financially viable and closed its doors in March, 1985.

Other health care providers within Lincoln County include two nursing homes, two residential care facilities, two Home Health agencies (both hospital based), and about fifty licensed physicians.

North Lincoln and Pacific Communities Hospitals have 49 and 46 licensed beds, respectively. Both hospitals provide a similar array of services including acute, general medical and surgical care, obstetric, pediatric, and emergency care, in addition to a wide range of outpatient programs including Home Health, Home Care, Hospice, and Durable Medical Equipment rental programs.

Both facilities are "health district hospitals" with a limited tax base. Revenues from property taxes account for approximately six percent of total revenues for each facility. Since 1986, tax revenues have been required to offset operating losses incurred by both facilities.

Factors contributing to these operating losses include:

—a continuing growth in the elderly percentage of our patient population coupled with inadequate reimbursement from our largest payment source, Medicare, which represents over 50% of our total patient volumes; and

—a continuing increase in our indigent and uninsured populations due to a depressed Oregon economy, coupled with a Medicaid per capita reimbursement rate ranking 51st in the Nation.

Both North Lincoln and Pacific Communities hospitals have felt the impact of the current crisis in the form of manpower shortages, lowered census, operating losses, and the loss of five primary care physicians in the area over a two-year period of time. The threat of imminent closure became very real to us when we saw New Lincoln Hospital succumb to financial pressures and close its doors during 1985.

It was in recognition of such financial realities that North Lincoln and Pacific Communities Hospitals perceived the need to form an alliance to study common problems, identify common goals and solutions, attempt to achieve economies of scale where possible, coordinate and eliminate duplicate services whenever possible, and generally seek to lower the cost of providing health care without sacrificing the quality of such care.

The governing boards of North Lincoln Hospital and Pacific Communities Hospital began holding exploratory meetings early in 1988. Our governing boards formalized their desire to work together with resolutions pledging mutual aid and support in June 1988.

A substantial list of topics for mutual consideration has come out of these meetings, some which will be addressed below. These meetings already have led to action, including the sharing of medical technicians, formation of a nursing relief pool, agreement to participate in joint fund-raising efforts, formation of a joint legislative action committee, the joint purchase of equipment, the sharing of costs associated with acquiring a management training program, and sharing of expenses incurred in the recruitment of a urologist to serve both health districts.

In short, we are attempting to adapt to the changes imposed upon us within the constraints of our financial and human resources.

Our joint problem solving has, to date, defined the primary problem facing most rural hospitals as a problem of productivity. Simply stated, declines in our inpatient census have inhibited the productive use of our assets. For most rural hospitals, the development of outpatient programs has not generated sufficient revenues to offset the costs of providing inpatient care. Therefore, in our opinion, survival will require rural hospitals to identify ways to leverage more effectively our relatively fixed asset base.

To this end, our consortium has identified three primary means to enhance the productivity of our assets. First, we recognize the need to improve our operating efficiencies by reclaiming, where possible, economies attendant to higher patient volumes, or, stated another way, to reduce any operating inefficiencies attendant to reduced inpatient utilization. Second, we recognize that traditional planning processes are ineffective in facilitating our adaptation to the rapid changes we are experiencing and thus a new proactive, participative approach geared to the small hospital environment is necessary. And finally, we recognize that we must leverage the one resource with unlimited potential; our people. In order to leverage effectively our human resources we recognize the need to alter our structures, processes, policies, and procedures to capitalize on this unlimited resource.

The strategies to accomplish the above-stated objectives include:

—the formation of a "joint management and support service corporation" to reduce duplication of administrative overhead and to facilitate the reattainment of economies of scale; and

—the development of management and planning structures, processes, policies, and procedures to leverage more effectively our human resources;

Administrative services or functions anticipated for the "joint management and support services corporation" include medical records, quality assurance, peer review, utilization management, and continuing education of nursing and management personnel, line staff, trustees, medical staff, and community members. Anticipated economies will enable the expansion of clinical programs such as nuclear medicine, as well.

Additional economies are anticipated by the elimination of costs associated with duplicative laundry, dietary, biomedical equipment maintenance, and the maintenance of independent relief pools of expensive clinical personnel. An equally important benefit attendant to the consolidation of some clinical management positions, however, will be the capacity to restructure these "working manager" positions to avail more time for proactive planning and leadership tasks, now absent due to the daily demands of patient care.

In order to realize the potential of our most critical resource, people, our planning and management processes will be restructured to solicit the participation of all our personnel in the planning and achievement of a desired future. This objective will be accomplished by providing all our staff with requisite training and through a restructuring of our planning processes. Our management staff will be trained to facilitate participation and organization-wide acceptance of responsibility. Line staff will be afforded training in empowerment skills and will be included in the entire strategic planning process from the determination of our mission to the implementation of tasks to accomplish stated goals and objectives.

An "Innovation Fund" has been created to provide the resources for individuals to pursue innovative ideas. This fund may be accessed to provide replacement staff to enable an individual to pursue an innovative idea or to acquire such training or consultative help as necessary to accomplish the same end. And finally, we are in the process of developing an incentive-based compensation system to serve as a model for small rural hospitals.

We recognize that much of what we are doing is not new. However, the application of these principles in the rural hospital environment may enable Lincoln

County, Oregon, to continue to receive accessible, high quality health care in an era of fiscal constraints.

In summary, we believe that rural hospitals have responded to the cost-containment mandate. We also believe that further gains can be achieved only through such cooperative endeavors. However, further cuts in Medicare funding for rural hospitals most certainly will imperil the quality of care we are able to provide to our elderly Medicare beneficiaries, at the least, and at worst, will eliminate access to health care due to further hospital closures.

Thank you for providing me with this opportunity to contribute my views on this vital national issue.

PREPARED STATEMENT OF SENATOR JOHN H. CHAFEE

Mr. Chairman, I do not want to take up much of the committee's time or detract from the main purpose of today's hearing, which is to delve into the problems of rural hospitals. I do, however, want to take this opportunity to make an important comparison.

Just yesterday, there appeared in the *Providence Journal* the latest in a spate of recent news accounts documenting the financial problems of my State's hospitals. The headline: "Rhode Island Hospital begins job cut in effort to reduce deficit." The article goes on to say that R.I. Hospital, the second largest private employer in the State, last year posted a $12 million deficit, and expects the same for the current year. In response, it plans to reduce its payroll by 10 to 15 percent over the coming year, which translates to a loss of 500 to 600 jobs.

The loss of jobs is not the only troubling prospect here. The loss of access to health care is yet another. In the very same way that the rural members of the Committee worry about rural hospitals closing, I worry abut urban hospitals closing. In Rhode Island, we have 17 hospitals. Our occupancy rates average about 75 percent and frequently exceed 80 percent. We simply cannot afford to lose a single one of these hospitals, because the system just does not have the capacity to absorb additional patients. When an urban hospital operating near full capacity closes—and all the other hospitals in the area are also operating near full capacity—the *effect is exactly the same as when a rural, sole community provider hospital closes.* In each case, the result is that the patients have nowhere to go.

In the years since the establishment of the Prospective Payment System, I have become increasingly concerned about the financial shape of hospitals in general. In my view, the problem does not lie with some inherent flaw in the prospective payment system. Rather, I would say that the problem lies with fact that we have not allowed prospective payment to work as it was designed to do. For example, there has not been a single year since the establishment of PPS in which hospitals have received a full update as anticipated when the law was enacted. There can be no doubt that this is a major contributor to serious financial problems in hospitals both rural *and* urban.

My great concern is about the troubles we are now seeing hospitals that should theoretically be operating at economic equilibrium—that is, they have occupancy rates of 80 percent and higher, are non-profit, and have an abundant patient base. When these hospitals begin to go under we will know we are truly in deep trouble. These hospitals are the mainstay of our system: they are located in high-need areas are serving high numbers of low-income and uninsured people. Closures among these mainstay hospitals will create upheaval in the system which it will be unable to absorb and will create serious problems of access to care.

We are beginning to see this happening in my State of Rhode Island and in cities across the Nation. I believe this threatens to throw our system into chaos. We need to get all hospitals on a more secure footing, and that is the goal I will be working toward throughout this year's reconciliation process.

Thank you, Mr. Chairman.

(From the Providence Journal, May 3, 1989)

R.I. Hospital begins job cut in effort to reduce deficit

PROVIDENCE — Rhode Island Hospital has begun eliminating jobs to attack its deficit by shrinking its payroll, which in most hospitals accounts for 60 to 70 percent of operating expenses.

However, hospital president Louis A. Fazzano said every employee whose job is eliminated will be offered other positions in the hospital, though not necessarily comparable in pay or stature. The employees have 90 days to decide whether to take the alternative job.

With 5,000 employees, Rhode Island Hospital is the second-largest private employer in the state, after Electric Boat in North Kingstown. Last fall, it posted a record $12 million deficit, and projects $12 million in additional losses this fiscal year, even with spending and staff cuts.

About 10 employees, most in administrative positions, were notified last week that their jobs were being eliminated, Fazzano said.

The hospital also is reducing staff through attrition.

"Anybody who leaves, we will say that job no longer exists," Fazzano said. "Then we will sit down and figure out the best way of getting the work done."

The hospital's average employee turnover is between 10 and 15 percent annually, so Fazzano estimates a minimum of 500 to 600 jobs will be available for elimination or redefinition.

The goal is to reduce employment without layoffs, which the hospital has pledged to avoid.

None of the payroll reduction plans will affect job benefits, Fazzano said. For example, being on maternity leave will not automatically kick an employee's job into the elimination category.

And Fazzano said payroll reduction is not the hospital's main strategy for reducing the deficit.

"If we were to balance the books through payroll, we would have to let so many people go that we couldn't run the hospital," he said.

PREPARED STATEMENT OF SENATOR BOB DOLE

Mr. Chairman: I feel as if I am singing to the choir. The witnesses before us today know far better than you or me what the problems are for rural hospitals. It is incumbent upon us to find ways to solve these problems that don't create new ones.

As you all know, when we first put the Medicare Prospective Payment System into place, we acknowledged that the new system might well have a negative impact on some rural hospitals—and our fears have been realized.

For the last three years, more rural than urban hospitals have closed—at a rate far greater than in previous years. These closures place at risk the health and well being of those who live in these areas. They also place the areas at further economic risk. As many of you know, the rural hospital not only serves as the primary source of care in these communities, it is often the largest employer.

There is, of course, great debate over the reasons for these closures and for the generally poor financial condition of these rural hospitals. As a result, it is difficult for us to know how best to proceed.

The distinguished chairman and I in introducing S. 306, and I in introducing S. 10, have tried to address those issues that were most obvious to us. For example, we modify the urban/rural differential and the criteria for sole community hospitals. We also recognize that some hospitals are trying their best to modify their services, so we increase funding for transition grants. We also tried to acknowledge the very real problems of the health manpower shortages being faced by many of our cities and towns. But not withstanding our attempt to touch on as many problems as possible, I'm sure there are suggestions as to what else we might do or what we might do differently. I know, for example, that the 70 percent Medicare share requirement in our bill is considered by some to be too high.

So we are here to listen and learn from you. I thank you all for joining us. In particular, I want to thank Curt Erickson from my home State who has been an extraordinary representative of rural hospitals. We are very proud of Curt and his contributions to ProPAC and are grateful for all of the assistance he has given over the years.

PREPARED STATEMENT OF SENATOR DAVE DURENBERGER

Mr. Chairman, I commend you for convening this hearing to examine the financial condition of rural hospitals and their ability to deliver health care to Medicare beneficiaries. This is not a Texas issue, nor a West Virginia issue nor even just a Minnesota issue. This is an issue for the entire country. Every State in our union has citizens residing in rural areas who are entitled to access to competent, affordable health care services.

Over the past two years, I have conducted at least 30 hearings around my State to collect information on these issues. I have visited numerous Minnesota rural hospitals, more even than most pharmaceutical salesmen! I personally have seen the evidence of (1) doctor shortages, (2) nursing shortages, and (3) related stress for families and the community.

Rural hospitals face a multitude of pressures related in part to the changing demographics and economic environment of rural communities. As a former Chairman of the Subcommittee on Intergovernmental Affairs, I became acutely aware of the extent to which the country as a whole is developing a two-track economy. The more prosperous one is centered in major cities on both coasts, and in stark contrast, the "heartland communities are in recession. As we have de-centralized, deregulated, de-funded and privatized, it has become evident that small, local communities have experienced serious declines.

In fact, rural areas face higher rates of poverty and unemployment, a lower percentage of insured residents, an eroding and aging patient base, and more acute shortages of health personnel.

The level and distribution of Medicare program payments is clearly not the only issue challenging rural health care delivery, but it is a major one. Recent reports of the Prospective Payment Commission and other groups make it clear that rural hospitals continue to experience relatively poor financial performance under the Medicare prospective payment system. In particular, small rural hospitals are most vulnerable to wide fluctuations in volume and case-mix, and have had the lowest average operating margins over the first four years of the prospective payment system.

Mr. Chairman, every year for the last several years I have introduced or supported legislation to improve equity in payments to hospitals across geographic boundaries. I am pleased to be a cosponsor of S. 306, and I look forword to hearing testimony on it today.

However, the future of rural health care does not reside exclusively with hospitals. Rather, it will depend upon innovative and effective partnerships among hospitals and other members of the provider community that address fundamental problems of financing and delivery of care. Therefore, I will shortly be introducing a separate bill to strengthen and expand support for the grant program for rural health care transition projects, which we created here in this Committee last year. In addition, we must consider opportunities for using the services of nurse practitioners and other professionals, as appropriate, to fill in gaps in the availability of services.

Enclosure.

GOVERNING THE HEARTLAND: CAN RURAL COMMUNITIES SURVIVE THE FARM CRISIS

Americans recognize that there is a farm crisis. The statistics, charts and graphs which underscore the problems are regularly featured in the nightly news:

—net farm incomes, measured in constant dollars, declined by 64% between 1979 and 1983. During the 1980's net farm income has averaged nearly 40 percent less than in the seventies.

—farm land values have fallen by more than 30 percent since 1981. In the five core states of the corn belt, the average acre of farm land is worth less than half its 1981 value.

—farm debt-to-asset ratios climbed 29% between 1979 and 1984; currently, one-sixth of all medium sized commercial farms and one-fifth of all large commercial farms are courting bankruptcy with debt-asset ratios over 70%;

—130 banks failed in 1985, the highest number since the Great Depression and four times the number of combined failures in 1979-1981;

Even these distressing statistics do not tell the full story. The human face of the farm crisis has also been the subject of much attention, including dark stories of personal losses and family tragedy. That these dimensions of the farm crisis command center stage is not surprising. But, they are only the first effects of a declining agricultural economy. The farm crisis threatens much of rural America in other less immediate ways, ways which are far less obvious but potentially as serious. Many rural communities are now questioning whether they will survive the financial stress brought on by declining farm incomes.

THE GOVERNMENTAL DIMENSION

As farm incomes and property values have declined, the State and local tax base has steadily eroded. Depressed conditions in the farm-dependent local business community have further increased the financial problems of rural communities.

At the local level, declining land values ultimately translate into declines in local assessed valuations—the cornerstone of most communities' property tax base. Increasingly, small town officials are faced with a choice between higher local tax rates or lower quality schools and other local services. This study documents those problems, and it finds the following:

—the real value of the agricultural tax base has shrunk by 20 percent or more since 1982, and is expected to decline further.

—tax delinquency rates have increased by 100 percent or more in many areas.

—declines in nonfarm incomes, employment, and property values caused by lower farm incomes magnify the farm crisis' impact on rural communities.

—declines in agricultural property values (other things equal) would produce a combination of tax increases and cuts in expenditures ranging from $13 to $199 per capita, based on 1982 spending levels in the agriculturally dependent counties studied.

Rural local governments face the prospect of a shrinking revenue base for the rest of this decade and longer. Ordinarily, they would turn to State government for assistance. But, farm problems also affect State revenues, particularly in those States whose economies are most dependent on agriculture.

—In three of eight states examined, state personal income lagged at least 20% behind the national average between 1982-1985;

—Since 1984, state government tax collections lagged at least 20% below the national average in five of the eight states this study examined.

—Seventy-five percent (more than twice the national average) of the agricultural states studied reported mid-year reductions in their 1986 budgets due to smaller than anticipated revenue collections. State aid to education has been cut in five of these same eight states.

Revenues are being squeezed at both the State and local levels, but service demands are increasing. Emergency hotline programs to give emotional and financial counseling to farm families have been established, and more than $100 million annually redirected to provide direct assistance to troubled farmers. Off-farm unemployment rates also are trending upward in five of the affected States, in marked contrast to falling unemployment nationwide.

Federal government cutbacks will add to the problem. Between 1980 and 1985 there was a 23 percent cut in real dollars in the amount of Federal aid provided State and local governments. Prospects for additional aid given Gramm-Rudman budget restrictions look bleak, and General Revenue Sharing, a source of substantial aid for rural communities, is scheduled to terminate in 1986.

In short, the farm crisis has an important third dimension—a governmental dimension—which both reflects and magnifies the economic problems now confronting farmers, bankers, and rural local businessmen across America's heartland. In some areas the revenues needed to support even minimally adequate elementary and secondary education programs and other necessary social services may not be available in the future. Severe long term dislocations affecting the national economy are possible.

Intelligent policy decisions, implemented now at the Federal and State as well as the local level, will help communities overcome the problems brought on by the farm crisis. But, the stakes are high. If the deterioration of the public sector is ignored, it may contribute to the creation of separate societies for rural and urban residents—societies with vastly different standards of living and qualities of life.

THE AGRICULTURAL ECONOMY OF THE EIGHTIES

Economic hardship is nothing new for rural America. In 1950, more than 23 million people lived on farms, and average farm incomes were substantially below those in the non-farm sector. Those low farm incomes, coupled with technological change (primarily increased mechanization) and the lure of higher wage urban jobs produced a large outmigration of low-wage farm laborers and small farmers during the 1950's. Still, per capita disposable incomes of farmers averaged only 65 percent of those of nonfarmers from 1960 through 1969, and outmigration continued. By 1970 less than 10 million farmers remained.

During the 1970's farm incomes improved. From 1971 through 1975 per capita disposable incomes of farmers averaged better than 90 percent of those of nonfarmers, as ever expanding export markets reduced excess capacity. Net farm income grew to average $41 billion ($1982) for the decade of the seventies, a 20 percent real increase over the $34 billion average of the 1960's. Farm populations continued to decline, however, dropping to 7.2 million by 1980.

Since 1980 net farm incomes have fallen precipitously. From 1980 through 1984 real net farm income averaged only $25 billion ($1982) down nearly 40 percent from the average of the seventies, and more than 25 percent from the average of the sixties.

Today's farm income problems will not be solved by consolidation, mechanization and migration to urban areas. Most savings available from those measures have been exhausted. Nor is it likely that exports will provide the same stimulation they did in the 1970's. Instead, farm asset values are being written down either explicitly when land is sold, or implicitly through declines in individual farmer's wealth, until values are reached at which returns comparable to those on investments elsewhere in the economy can be attained.

The result of this asset re-valuation has been a steady decline in the value of farm land since 1981. Nationwide, USDA estimates that agricultural land values have fallen by more than 30 percent, from $823 per acre in 1982 to $596 per acre in 1986. The declines have been even greater in the grain producing areas of the midwest. (fig. 1) Farm land values fell only one other time in the postwar period, in 1954 when they dropped from $83 to $82 per acre.

When viewed in real dollars—that is in dollars of constant buying power—results are even more sobering (fig. 2) The real value of farm land has declined only 12 times since 1945. Four of those years were scattered through the fifties, and two were in the early seventies. The remaining six have come since 1981. Nationally, the real value of farm land has retraced all increases since the early seventies, and still seems not to have reached a bottom.

The losses in individual wealth, and in the real buying power associated with that wealth, are enormous. Between 1982 and 1985 USDA estimates that farm land values fell by $146 billion. These losses have caused great personal hardship to America's family farmers. While the magnitude of their losses is almost impossible to comprehend, some perspective can be gained by noting that personal losses in farmer wealth, $146 billion, were slightly more than the total value of all farm real estate in the states of Illinois, Wisconsin, Minnesota, North Dakota, South Dakota, Iowa, and Nebraska in 1985. Put another way, the loss in farm real estate values between 1982 and 1985 is equal to the combined assets of IBM, General Electric, Eastman Kodak, 3M, Proctor and Gamble, Dow Chemical, McDonalds, RCA, Upjohn, Weyerhaeuser, and CBS.

This same decline in land value will eventually be reflected in reductions in the local property tax base. Rural local governments will be faced with the problem of funding adequate levels of public services from declining revenues. The write down of agricultural property values, and the accompanying decreases in the local tax base have the potential to permanently change the quality of life in rural America, particularly in those regions primarily dependent on agriculture.

PROPERTY TAX IMPACTS IN AGRICULTURALLY DEPENDENT COUNTIES: DETAILED ESTIMATES

The restructuring of agriculture is underway, and it is beginning to affect rural local governments. Early recognition of the severity of those problems likely to emerge is essential if solutions are to be found and permanent, long term damage avoided. Unfortunately, national data do not exist which are both timely and in sufficient geographic detail to allow identification of those communities and regions where the local impacts of decreasing farm incomes and land values have been the greatest. The Census of Government, the most recent nationwide compilation of data on all units of local government, was last conducted in 1982. Virtually all the declines in land values have occurred since that time, making that data useful for marking the peak of rural local government's prosperity, but inappropriate for measuring the impacts of recent fiscal stress.

To compensate for the lack of timely national data on changes in rural local government finances, this section presents primary data collected from local governments in rural, multi-county regions in eight states (Arkansas, Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska, and North Dakota) thought to be particularly hard hit by the farm crisis. Financial records for recent years were collected from State and local governments in the sample region, and supplemented by a telephone survey of local officials.

Because the impact of declining farm property values on local government depends heavily on how important agriculture is to the local economy, crop reporting districts with a high percentage of agriculturally dependent counties as identified by USDA's Economic Research Service (Bender, et. al., 1985) were used as the units of analysis. A map outlining the eight crop reporting districts surveyed is given in figure 3.

Counties were considered by USDA to be dependent on agriculture if a weighted average of at least 20 percent of all labor and proprietor's income from 1975 through 1979 came from farming. Twenty-nine percent of all non-metro counties, 702 counties, met that criterion. These counties are not the only ones to be affected by declining farm incomes and lower land values. They are, however, those in which impacts will be most severe.

Focusing on agriculturally dependent counties is appropriate because large decreases in agricultural incomes and land values may have relatively little impact on the public sector in areas where manufacturing, mining, or forestry dominate, even though impacts on the wealth of individual farmers will be similar. For communities where agriculture is the major source of income and wealth, however, even modest percentage reductions in agricultural property values may have major impacts on the local tax base and on local government.

Agricultural Land Values in Selected Crop Reporting Districts

Nationally, the real, per acre value of farm land (land value in current dollars divided by the consumer price index) began trending down in 1980. By 1986 it had decreased to a level equal to those of the early 1970's. Only three States outside New England have seen increases in farm land prices since 1981. In ten States—Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, Ohio, South Dakota, and Wisconsin—declines of over 40 percent in farm land value were observed. Three States—Minnesota, Iowa, and Indiana—have had farmland drop in value by more than 50 percent.

USDA estimates of changes in land values in each of the crop reporting districts, are shown in figure 4. Values in both current and 1985 dollars (deflated by the GNP personal consumption expenditure deflator) are shown for the years 1977–1985.

The pattern in each crop reporting district surveyed is nearly the same. In current dollars, land values increased by 50 percent or more between 1977 and 1981, only to drop back to 1977 or lower levels by 1986. Farmers have lost an enormous amount of their personal wealth. In Minnesota alone, the loss in farm real estate values between 1982 and 1986 was in excess of $20 billion, or an amount equal to the current (1986) value of all farmland in Missouri, or Kansas, or Nebraska.

Looking at changes in land values in current (non-deflated) dollars understates the extent of the potential problem facing local governments. To see the true impact of those lower land values one must compare using dollars of constant buying power. If local revenues are to be sufficient to continue public services at the same level without a millage rate increase, the local property tax base must increase in value at the same rate as inflation. If the real value of the tax base declines, even though the value in current dollars increases or remains constant, higher tax rates will be necessary to maintain existing service levels.

Land values in real, 1985 dollars also are shown in figure 4. Their pattern is substantially different. Only in Arkansas did values increase over 30 percent. In Kansas and North Dakota real values actually declined between 1977 and 1981. Elsewhere increases from 1977 to 1981 were more moderate, reflecting the fact that during that time prices of all tangible assets increased rapidly due to inflation. Once land values began to decline, however, inflation adjustments accentuated their decline. Since 1981 many counties have seen more than a 50% drop in the real value of farmland.

This decrease in farmer wealth affects local consumer buying patterns and farm management decisions and thus spreads through the region's economy. The local public sector is one of the areas most severely affected. If the local tax base were comprised entirely of agricultural land, and assessments tracked land values precisely, a decrease of 50 percent in land values would cut in half the quantity of goods and services which local governments could provide given the tax revenue from a fixed millage levy. Local officials in this situation are faced with a no win set of choices—either increase taxes or cut essential services.

In reality the local tax base includes more than agricultural land, even in the most agriculturally dependent county, and assessed values have not followed farm land values perfectly. Further, not all local government revenues come from property taxes. Each of these factors will moderate the impacts of declining farm land values on the local public sector. Differences among States in these variables are examined below.

Assessed Values

Agricultural land made up varying proportions of the local tax base in the study States. (figure 5) In the Nebraska, Iowa, Minnesota, North Dakota crop reporting districts chosen, more than 45 percent of the local property tax base was classified as agricultural land. The Minnesota crop reporting district, with 78 percent of the property tax base agriculture was the most dependent.

In Montana and Kansas, less than 15 percent of assessed value is agricultural because oil and gas producing properties are also located in the crop reporting districts studied. Income from such property is included in the local property tax base, and dominates the value of all other property. In those regions, even though agriculture is the major source of income, it is not the major source of support for local government. When oil and gas prices are high and agricultural land values dropping, this diversification of the local tax base eases fiscal pressures on local government. But, if oil and gas prices fall, as has recently occurred, local financial problems will be magnified.

Agricultural assessed values for 1981-1985 in each of the 8 multicounty crop reporting districts examined are shown in figure 6. To emphasize the impact of changes in agricultural income on local government's purchasing power from a fixed millage rate, assessed values in 1985 dollars are also shown.

From 1981 to 1985, agricultural assessed values in current dollars remained relatively constant in most states. Only in Minnesota did assessed values increase as property values increase, then decline as agricultural land values fell. The relative stability of agricultural assessed values during this time of volatile land prices is due to the methods used to establish a value for agricultural property. In all States surveyed except Minnesota and Kansas, agricultural assessed values are based on a measure of the land's productive capacity, not on market prices. In Missouri and Arkansas the soil productivity grade determines assessed values. In Iowa, Nebraska, and North Dakota estimated net income as well as soil productivity is taken into account. Further details of assessment procedures in the States surveyed are given in figure 7.

These special provisions for valuing agricultural lands prevented a run up in assessed values during the last part of the boom in agricultural land prices. They also have, to this point, prevented a decline in the agricultural portion of the local property tax base. Only in Minnesota, where actual market values are the basis for assessments, has there been a significant drop in assessed values.

One should not expect that agricultural assessed values will continue to hold at the same level though. Future soil productivity tables will almost certainly be revised downward to reflect the lower earning power of farm land. And, as lower net farm incomes are factored into state assessment formulas based on a combination of soil productivity and expected farm income, agricultural assessed values will fall. The current restructuring of agriculture will cause a drop in agricultural assessed values, and Minnesota, where market values determine assessed values, will not be alone in seeing substantial declines in the value of its agricultural tax base.

The importance of thinking in terms of real, constant buying power dollars, rather than current value dollars is apparent when the trend in agricultural values in 1985 dollars is examined. (figure 8) Even though assessed values did not decline from 1981 to 1985 in most regions, the buying power of the funds raised through levying a constant millage rate shrank approximately 20 percent, since agricultural assessments did not keep pace with the inflation in the rest of the economy. As a result, upward pressure on millage rates exists even now in many rural communities.

Downtown Property Values

When farm incomes decline, main street spending falls. Jobs in the local commercial sector disappear, and incomes in that sector decline as well. Downtown property values reflect the net income which can be earned from that property, so over time the commercial property segment of the local property tax base also will decline. And, as with agricultural property, these declines will not occur instantaneously. Instead, they occur gradually over a number of years as some businesses close and others relocate.

The impact of declining farm incomes on the main street business community was estimated using data from Minnesota's CRD7 located in southwestern Minnesota. A simple econometric model was constructed which estimates changes in local income, employment and property values associated with changing farm incomes.

Some specific findings are summarized below.

—A $1000 change in net farm income produces $190 change in the net income of the region's merchants. This is substantially less than the impact from a similar sized increase in manufacturing incomes or transfer payments.

—Main street employment also depends on the income of the region's agricultural sector. A long term increase or decrease of $64,000 in net farm income will add to, or cutback local commercial employment by one job. Again, the multiplier for agricultural income is less than that for manufacturing or transfer payments. It is important to note, however, that the job estimates are the total of full and part-time jobs, not solely full time equivalent positions.

—Downtown property values decrease by approximately $15 for each permanent $1000 decrease in agricultural incomes. The adjustment process is slow, however, taking more than 5 years to complete after the change in income is recognized as permanent

—Impacts of the recent decline in farm incomes depend on the year chosen as the baseline. If one chooses the historically high income years of 1974-1977 as the baseline, and assumes that the level of permanent income observed in 1983 will continue in the future, then, other things equal, the decline in farm income has caused a decline of $47 million in off-farm income, and there are 3,650 or about 15 percent fewer commercial sector jobs. Downtown property values will eventually decrease by about $3.1 million.

—When a period with lower levels of agricultural incomes is used as the baseline, impacts on jobs, employment, and property values are smaller. If farm income had held at 1979-1981 levels, other things equal, local incomes would be $22 million greater and today the local commercial sector would employ 1,735 more full and part-time workers. In addition, the ultimate decrease in downtown property values would be about $1.5 million less.

—These estimates are specific to Southwest Minnesota and do not take into account impacts which might occur outside the region's boundaries in trading centers such as Mankato, Minnesota; Sioux Falls, South Dakota, or Minneapolis-St. Paul. If impacts in those cities were counted, multipliers would have been larger. The estimated impacts are expected to be typical of those which would occur in other agriculturally dependent regions in the upper midwest not containing a major trade center.

—There are several reasons for caution in using these estimates. They are based on a relatively short time period dominated by increasing agricultural incomes. If the local commercial sector does not respond symetrically to increases and decreases in local income, impact estimates will be either over or underestimated. In addition, local firms are unlikely to shutdown after only one bad year. Instead it will take the perception of continued, long term losses to produce a shutdown decision. Small town businessmen may not have shifted to long run thinking prior to passage of the 1985 farm bill. Now, with better information about future levels of farm income, shutdowns may accelerate.

Delinquency Rates

Property tax delinquency rates vary from State to State, and even within States. Delinquencies depend on the penalties and interest charges assigned, the market interest rate, local customs, and the health and makeup of the local economy. In some areas six percent or more of the total net levy might be expected to be unpaid a year after property tax collections were scheduled to be completed. Elsewhere, one percent or less might remain outstanding and be declared delinquent. Local officials take expected delinquency rates into account in their planning and delinquencies cause little financial stress, no matter what their level, as long as they are a relatively stable percentage of the tax levy.

Sudden increases in delinquency rates are warnings that something is wrong with the system. It may be simply that market interest rates have increased to a level at which it is profitable to use unpaid property taxes as a source of capital, paying interest and penalities to the local government instead of a bank. Or, it may be symptomatic of fundamental problems with taxpayer's farm, or business, or in the local economy. For those already in financial difficulty, property taxes become just another bill that cannot be paid. Wide spread increases in delinquencies, especially on farm property, may indicate that assessed values are too high and that assets need to be revalued to reflect their current value, not their value in the past.

Property tax delinquencies increased substantially in dollar terms between 1980 and 1985, in agriculturally dependent counties. In the Nebraska counties studied, delinquent taxes increased seven fold, growing from a total of less than $.75 million in 1980 to more than $5.5 million in 1985. (figure 9) Delinquencies in Iowa, Kansas, Minnesota, and Montana also more than doubled.

When viewed as a percentage of total collections, delinquencies also increased substantially. (figure 10) Nebraska showed the largest increase. Between 1981 and 1985 the percent delinquent grew by 378 percent rising from 1.75 to 9.5 percent. Minnesota, Iowa, and Montana again showed increases of over 100 percent.

Property Taxes as a Percentage of Total Revenues

The impacts of declining agricultural property values and lower downtown property values on the ability of local government to finance essential services will depend on the proportion of local revenues coming from the property tax. Differences in local government's reliance on the property tax in the crop reporting districts studied are shown in figure 11.

Property taxes are more than 40 percent of local revenues in Montana, Kansas, and Nebraska, and less than 20 percent in Arkansas and Missouri. As a general rule when property taxes are a smaller percentage of total revenues, State aids are larger. Charges and miscellaneous revenues and Federal aid (including revenue sharing) were relatively constant in all of the sample crop reporting districts.

These results help to further identify those regions where declining farm land values are likely to produce the most stress for local governments. Clearly, Nebraska communities are at substantial risk since agricultural values make up a sizeable portion of the local property tax base and more than 40 percent of 1982's local government revenues came from the property tax. The Montana and Kansas crop reporting districts surveyed are less exposed to stress from declines in agricultural values because proceeds from the region's oil and gas wells are part of the local tax base. But, declining oil and gas prices may produce a similar reduction in the property tax base.

In States such as Minnesota, Iowa and North Dakota, where property taxes provide between one-third and one-fifth of local revenues, the outlook, while not as strained as in Nebraska, is certainly not optimistic. Agricultural values remain a major component of the local property tax base, and further declines will force millage rate changes if localities are to maintain existing service levels.

A SMALL TOWN FEELS THE FARM CRISIS

Fulda, a town of 1300 in southwest Minnesota, underscores how the effects of the farm crisis have spread beyond farm fields to small towns across the Midwest. Outside the city limits, the story is a familiar one: farmland values in surrounding counties have declined by more than 50 percent since 1979, the county's population is down, and property tax delinquencies are skyrocketing.

In Fulda, these agricultural problems have affected local business sales and employment, real estate values, property tax rates, and service demands.

- retail sales declined 55 percent between 1979 and 1984, falling from 7.5 million to 3.4 million;
- six businesses closed in 1985 alone, eliminating 21 jobs;
- a local bank failed;
- five homes were foreclosed in 1985;
- city lots declined in market value from $10,000 in 1979 to $3,500 today;
- from 1984 to 1985, property tax delinquencies more than doubled, rising from $6,700 to $14,905;
- city revenues declined 9 percent between 1982 and 1984 (falling from $463,178 to $421,953);
- an $80,000 rise in local government expenses during the same period required an 8 percent increase in local taxes last year and a projected increase of 15 percent next year, along with an automatic increase in state school foundation grants; and
- free and reduced price school lunches rose 35 percent.

OTHER SOURCES OF LOCAL GOVERNMENT REVENUE

During the past two decades, all local governments have become less reliant on property taxes. Now, the property tax is no longer the largest source of local revenue either nationally or in agriculturally dependent counties. Unlike the early 1960's when almost half of all local revenues (48 percent) came from property taxes, today's rural communities receive more from State aid (37 percent) than from property taxes (27 percent) Federal aid (6 percent), charges and miscellaneous revenue (25 percent) and other taxes (4 percent), provide the rest.

Agriculturally dependent counties and metropolitan areas did not differ in the average proportion of local revenues obtained from property taxes. But, that relationship varies from State to State, and even community to community depending on State aid formulas and who has responsibility for providing services such as welfare and highways.

Once, fiscally strapped local governments could turn to the States and to the Federal Government for assistance during hard times. In the late 1960's, for example, the difficulties of the inner cities were eased by special Federal and State programs targeting aid toward the affected communities. In this way, funds from suburban and rural taxpayers were directed into problem areas of the central cities. Today's conditions are different and rural areas are unlikely to benefit from increases in Federal and State aid. Instead, independent Federal and State actions, unrelated to the farm problems, could add to the financial problems of rural local governments.

Federal Aid

In 1982 Federal aid, including general revenue sharing, totalled less than 10 percent of revenues for local governments in the crop reporting districts studied. (figure 12) Some individual units of government, townships for example, received a greater proportion of their revenues from Federal aid, but variation across States and among types of governments was substantial.

Federal aid is only a small part of the local revenue base. But, Federal changes unrelated to the farm problem can add to the financial stress on rural local government. Between 1980 and 1985 Federal aid to State and local governments fell by 25 percent in constant dollars, and rural communities have not been spared their share of those cuts. Further, the need to meet Gramm-Rudman deficit targets is expected to force additional cuts in the aid programs available to localities. The National Association of State Budget Officers estimates additional cuts of 20 percent in State-local aids will be required by 1990. Revenue sharing, the major source of Federal aid for many nonmetro localities, is also scheduled for elimination. Rural communities cannot expect real increases in Federal aid under existing programs. More realistically, they should expect further declines.

State Aid

States also may be unable to provide additional aid. The decline in farm income is cutting State revenues as well, especially in States where local government's problems are most severe. Six of the eight States included in this study were among the 17 States to report mid-year budget reductions due to smaller than anticipated revenue collections. Six of the study States also have either enacted or proposed a decrease in State funding for local schools. Clearly it is unrealistic to expect that lost property tax revenues will be fully replaced by State aid.

Results from a recent survey of State revenue growth by the Advisory Commission on Intergovernmental Relations confirm the pessimistic short term view. Of the

States in this study, only Nebraska and Missouri were expecting tax revenues to grow as fast as the national average. (figure 13) In Nebraska, the growth estimates assumed that the individual income tax rate would increase from 19 percent to 20 percent of the Federal tax liability.

State aid already was the single largest source of revenue for rural local governments, with about 38 percent of non-metropolitan local governments' revenues coming from that source in 1982. State aids provided about 40 percent of local governments' revenues in the nation's 702 agriculturally dependent counties. In the crop reporting districts surveyed, dependency on State revenues ranged from less than 20 percent in Montana and Kansas, to more than 40 percent in Arkansas, Minnesota and North Dakota. (figure 14) Where States try to make up all lost property tax revenues, State aids would make up well over 50 percent of local revenues in some regions, raising important questions about local control and the independence of local government.

States may still opt to provide additional funds to rural localities, but they should not be misled. The current drop in rural land values is not a temporary, short-term change which can be expected to quickly reverse itself. Instead, it is the result of a massive write down of the assets employed in agriculture. In the absence of major shocks to the world's food production system, or a large change in demand for U.S. agricultural products, agricultural land values are unlikely to recover to the real values of the late 1970's. This means that State assistance, if it is offered, must be considered a long term commitment to rural areas and not simply a temporary measure.

NORTH DAKOTA: A STATE UNDER FISCAL STRESS

Faced with both an agricultural recession and a rapid downturn in oil prices, North Dakota's budget has come under severe fiscal stress. In FY 1986, State revenues declined 19.5 percent, forcing mid-year cuts in the State's FT 1986 budget.

Education has been especially hard hit. Per pupil grants of State aid to education have already been reduced 4 percent (from $1425 to $1370 per pupil), and the State education association anticipates that additional across-the-board cuts in the State budget will further reduce State education aid. As a result, total State aid to education has declined from 63 percent of total education costs per pupil to 44 percent today.

What does this mean in terms of education services? It means:

- cuts and eliminations of home economics, vocational education, and elective courses;
- predicted teacher layoffs of 400-500 teachers Statewide;
- a decline of 55 percent in North Dakota's ranking in paying teachers' salaries, from 29th in 1981 to an estimated 45th in 1986.

LOCAL GOVERNMENT EXPENDITURES

By themselves today's farm problems will not bring financial stress to all rural local governments. Even if only agriculturally dependent communities are considered, there will be substantial differences in the impact of the farm crisis on local public services. The proportion of local revenues which comes from the property tax and the ratio of agricultural property value to total assessed value vary widely both among and within States.

Still, the possibility of having to choose between lower service levels and higher taxes is a real concern throughout rural America. Northeastern Nebraska, where nearly one-half of all local revenues come from the property tax and where farm land is 45 percent of the local property tax base is a clear example of a region where declining farm land values could create sizeable reductions in future local government revenues. Even localities in the Kansas and Montana crop reporting districts studied may face stress when declining energy prices cause oil and gas property values to fall, reinforcing the trend created by declining agricultural land values.

This section provides needed background for a more detailed examination of the likely impact of declining agricultural tax base on local government revenues. It begins with a brief description of problems with using expenditures as a measure of local government service levels. Existing (1982) spending levels in the study counties are then examined to see whether agriculturally dependent regions are providing higher levels of government services than are available elsewhere in the nation, and whether rural service levels increased during the prosperous years of the 1970's relative to the services offered elsewhere. Finally, the types of government most likely to be adversely affected are identified.

Expenditures as a Measure of Service Quality

Physical measures of the quantity and quality of services provided by local government are not widely available. Consequently, analysts are forced to use per capita expenditures, or per pupil expenditures as a proxy for government service quality. Such an approach assumes that if a locality spends $1 more per capita than its neighbors, its residents receive either more or higher quality services, an assumption which does not always hold. Differences in production costs can make comparisons of expenditures among communities misleading.

Size economies and differences in service conditions are the major sources of differences between actual service levels and per capita expenditures. Economies of size—that per unit costs of services decrease as the population of the community increases—are well known and accepted as an important source of differences in per capita local government expenditures. (Fox)

Service conditions are equally important, but they are often overlooked. Their contribution can best be explained by noting that local residents demand results, not fixed dollar amounts of spending. For example, for police protection what local residents are willing to pay for is a reduction in the probability that members of their household will be affected by crime. They are unconcerned about the number of man hours of patrols required to provide a particular level of safety, and in theory are willing to pay the same amount whether it takes one patrol per week or one patrol per hour. As a result, localities spending $5 per capita and those spending $50 per capita could be receiving identical levels of services with the difference being a lower underlying risk of crime where expenditures were lower.

These and other problems with local spending data restrict interpretation of inter community differences in local government expenditures. (Stinson, 1981) They do not completely invalidate such comparisons, however. While it is impossible to say that a community spending $10 per capita more than its neighbors is offering higher quality services, a 10 percent cut in expenditures will lower service levels in any community. Further, communities where expenditures have not increased as rapidly as national averages are unlikely to be increasing their service levels relative to those elsewhere in the nation.

Local Expenditures

In 1982 per capita local government expenditures were less than the national average in 5 of the 8 crop reporting districts studied. (figure 15) Localities in the Arkansas and Missouri counties studied spent at approximately two-thirds the national average, while those in the Kansas, Minnesota, and Montana counties spent at least 25 percent above the national rate. In Iowa, spending was a smaller percentage of the U.S. average in 1982 than in 1972. In Kansas, Minnesota, and Montana per capita spending as a percentage of the national average grew substantially, perhaps reflecting the growth in the local property tax base due to increasing oil prices (in Kansas and Montana) and Minnesota's higher farm land values. Expenditures by the other local governments studied also grew, in real dollars as well as current dollars, but their growth rates were similar to those observed in communities throughout the nation.

When spending for local education is examined separately, schools in Kansas and Montana again were found to spend at levels substantially above the national average, while those in Iowa, Minnesota, Nebraska and North Dakota spent at approximately the national level. (fig. 16) Between 1972 and 1982 per pupil expenditures grew more rapidly than the national average in all but the Iowa, Minnesota and Missouri crop reporting districts studied. Again, while spending grew at the same time farm land values increased, local government spending also was increasing elsewhere.

These results provide little support for the hypothesis that counties where government service levels are most at risk due to falling land values were offering higher quality public services than were available in other communities. Nor do the data suggest that rural localities used the increase in land values during the 1970's to support higher service levels than they had provided historically.

Per capita spending for all locally provided services was 80 percent or less of the U.S. average in 5 of the 8 crop reporting districts examined. Of the three spending more than the U.S. average, Kansas and Montana both spent largely for local education, possibly because higher costs attributable to a lack of size economies and the low population density of the region. Only in Minnesota, where expenditures were slightly more than 25 percent above the national norm and State aids were a large proportion of local revenues, was there reason to suspect that rural service levels were above the national average. Even there, per pupil educational expenditures had dropped to only 3 percent above the national average between 1972 and 1982.

Impacts, by Type of Government

School districts and county governments are likely to be the levels of government most seriously affected by the declining property tax base. Since most farms are located outside city boundaries and thus not subject to city taxes, the major impact on city revenues will be through the accompanying decline in commercial market values. In the crop reporting districts studied, approximately two-thirds of farm property taxes went to fund the local educational system, about 30 percent for county services, and the remainder to townships and other special districts. While there was variation across States, differences typically were not large.

Existing State aid programs should help take up some of the shock to local educational systems. Depending on the nature of the State's school foundation aid program, State government may well cushion the shock of lower property tax revenue caused by declines in assessed values.

By guaranteeing that a specific dollar amount of revenue will be available for local services, State school foundation programs relieve some of the local fiscal stress caused by declining farm incomes and lower land values.[1] The relief will be very selective, however, depending on the characteristics of the State's foundation aid program. Table 1 gives an indication of the importance of the foundation aid program and State aid levels in general to local school districts, by showing the percentage of school district revenues coming from State aids. School districts in all of the study States except Missouri and Nebraska received at least 40 percent of their revenues from their revenues from State government.

TABLE 1.—STATE AID AS A PERCENTAGE OF REVENUES FOR LOCAL EDUCATION, SELECTED STATES

[In percent]

	1977	1982	1984	1985	1986
Arkansas	50.4	52.5	57.6	60.8	61.3
Iowa	39.5	42.5	42.5	40.7	40.7
Kansas	43.2	44.9	42.6	44.0	44.6
Minnesota	58.0	64.2	53.8	55.0	54.4
Missouri	34.6	38.9	36.3	36.5	38.9
Montana	51.3	44.5	51.7	51.7	51.7
Nebraska	18.1	29.9	29.3	28.1	28.1
N. Dakota	47.9	58.1	53.5	53.4	53.5

Source: Estimates of School Statistics, NEA. 1986 Estimates from Telephone Conversations with NEA.

A LOCAL SCHOOL DISTRICT GRAPPLES WITH FARM CRISIS

What does the farm crisis mean for local education? For 840 students in one rural Minnesota district, it means budget cuts, teacher layoffs, and service reductions.

Independent School District #417 is a rural district in Southwest Minnesota, covering parts of Redwood, Lyon, and Murray counties. Between 1983 and 1984, taxable valuations in the district fell $1.1 million, which contributed to a decline of almost 10 percent in the school district budget. This budget shortfall:

- swallowed up the district's reserve fund;
- forced the layoff of seven teachers;
- required cuts in administrative, clerical and custodial staff;
- cut the sports budget by 50 percent and eliminated two sports entirely; and
- eliminated a school bus route.

School district officials fear the worst is yet to come. When the current assessment cycle is completed, taxable valuations are expected to decline another 15 percent, starting yet another round of difficult cuts.

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[1] Minnesota's school foundation program, a relatively generous one, provides an example of how the State cushions local impacts. In 1986, school districts are guaranteed roughly $1700 per weighted pupil unit. Each district must levy a 23.5 mill property tax for operations and the State will make up any differences between the amount levied and the $1700 per pupil guarantee. If the district's assessed valuation is $50,000 per pupil, the 23.5 mill tax produces $1175 per pupil and the State contributes $525 ($1700–1175). If local assessed values drop by 50 percent to $25,000 per pupil, the State contribution would automatically increase to $112.50 per pupil ($1700–587.50).

This partial guarantee of local revenues has the potential to significantly reduce fiscal stress on the affected localities. But, it is important to note that foundation aid programs and other similar needs related programs will increase the fiscal stress on State governments, thus tieing State expenditures to shocks to the local property tax base.

For States with widely diversified economies, these programs offer a way of easing the financial stress on rural school systems. By raising additional funds from areas with a strong economic base through higher State sales and income taxes and then redistributing those funds to local governments in regions where the property tax base has declined, the need for local expenditure cuts will be lessened. But, such programs may not be acceptable to the public if they are seen as permanent transfers of income rather than temporary assistance.

If incomes in other sectors fall, as has happened in energy producing regions with the collapse in oil prices, Statewide cutbacks in all services may be necessary to match expenditures with revenues. This will further worsen local governments' problems. Transfer programs also are of little real value in States whose economy is heavily dependent on agriculture. If low farm incomes drive down the local tax base by depressing farm land values, State revenues will also be lower than expected, leaving no capability for intervention without increasing existing State tax rates.

Service Demands

Rural States and localities are being challenged, by rising service demands as well as falling revenues. As the agricultural recession grows broader and deeper, more rural Americans are turning—often reluctantly—to government for help. Governments throughout the farm belt are attempting to respond with job training programs for farmers forced off their land, emergency suicide prevention programs, stress and financial counseling programs, and a range of additional social services.

Many of the increased service demands are a direct response to rising unemployment. Although unemployment rates across the great plains and the corn belt historically average well below the nation's, as of January 1986 the unemployment rate in the eight sample States averaged one-half point above the national average and the gap was growing. Although the national unemployment rate decreased by 5.5 percent during 1985, unemployment rose in five of the States studied. Strong employment gains were evident only in Missouri, and if that State is excluded, joblessness across the States examined was nearly 10 percent above the norm.

Each of the States examined has initiated job retraining and career counseling programs aimed at helping displaced farmers find alternative employment. For those still struggling to keep their farms, individual States and localities, along with the cooperative extension service, are initiating and expanding programs of legal and financial counseling.

Rising unemployment and financial stress are taking a toll on farmers, their families, and surrounding rural communities, and placing strains on rural social service and mental health facilities. In one regional mental health center in southwest Minnesota, outpatient services are up 30 percent since 1984. Calls to their 24 hour crisis hotline are up 430 percent, visits to the 24 hour crisis drop in center, up 329 percent; and drug, suicide prevention, and family abuse consultations up 67 percent. Similarly, northern Iowa experienced a 5 percent increase in mental health hospitalizations in 1985 (despite a 7 percent decline in population), and social service requests jumped 30 percent.

Many believe that service demands are outstripping the ability of government to respond. One study of suicide and depression in rural Minnesota found that 3 out of 100 adolescents surveyed had attempted suicide within the past month—15 times the national average—and rates of depression were twice the national norm. The average depression score for these youths on one psychological test was greater than that for adolescents hospitalized at the UCLA Neuropsychiatric Institute. (Hoberman) Similarly high rates of severe depression were found among adults in a Missouri study. (Heffernan)

Governments have no easy answers to these problems. As revenues decline, spending on basic services, maintenance, and long term development will have to be cut and infrastructure projects deferred if more resources are to be devoted to emergency and employment services.

FUTURE IMPACTS ON LOCAL GOVERNMENT SPENDING

This report has concentrated on identifying the impact that declining farm land values will have on rural local government's property tax base. The public policy concern, however, is not changes in the local tax base, but rather changes in local government's ability to provide the essential services—the schools, highways, police and social services needed by those living outside the metropolitan area.

This section reports simple projections of the per capita amount property taxes will have to increase (other things equal) to overcome reductions in the local property tax base. The impacts of cuts in Federal and State aid, and general revenue sharing are also estimated based on data from the 1982 Census of Governments. The dollar amounts found should not be seen as estimates of the actual decline in spending which will occur in the absence of other revenue increases, but rather as a measure of the size of the deficit which local officials must overcome through a combination of reductions in services and higher taxes.

The projections which follow indicate that while the financial stress brought on by lower agricultural land values could probably be absorbed by local taxpayers, the combined impact of lower property tax receipts, and lower State and Federal aid will place a severe financial constraint on rural local government's ability to provide essential services.

Local Property Taxes

The impact of expected declines in agricultural land values on local government revenues was examined by assuming cuts of 10 and 25 percent in local property tax receipts. Then, holding other sources of revenue constant, the level of per capita expenditure consistent with the reduction in property tax receipts was found. The difference between actual 1982 expenditures and those taking into account reduced property tax revenues is the deficit facing local officials. Again, this shortfall assumes no changes in the level of Federal or State aid.

The cutback percentages assumed for the local property tax base, while arbitrary, provide realistic boundaries for the impacts of the decline in land values. A 25 percent decline is equivalent to a 50 percent drop in real land value in a region where agricultural land is 50 percent of the local tax base. Declines in the Minnesota's CRD 7, where agricultural land is more than 75 percent of the total tax base and where real assessed values have already fallen by 30 percent, are now approaching that level. The 10 percent decline (a 20 percent drop in real agricultural values when agriculture is 50 percent of the tax base) has been exceeded in several of the crop reporting districts studied.

The resulting deficits from 1982 spending levels for each of the study areas are reported in table 2 and shown in figure 17. As expected, given that property taxes provided less than half of local revenue in the crop reporting districts studied, the percentage declines were not dramatic. A ten percent drop in property tax revenues, other things equal, produced cuts in per capita expenditures ranging between two and five percent. Localities which spent less than the national average before would spend even less after those cuts. Those above, remained above, but not by as large a margin as before.

TABLE 2.—LOCAL REVENUE IMPACT OF A 10 PERCENT CUT IN PROPERTY TAX RECEIPTS, SELECTED CROP REPORTING DISTRICTS, 1982

[Dollars per capita]

Crop Reporting District	Operating Expenses	Revenue Loss
Arkansas 6	653	13
Iowa 1	839	45
Kansas 3	1487	80
Minnesota 7	1302	32
Missouri 2	664	20
Montana 2	1260	72
Nebraska 3	782	39
North Dakota 9	740	34

In dollar terms the local deficit from the 10 percent drop in property taxes ranged from $13 per capita in Arkansas to $79 per capita in Kansas. In four of the crop reporting districts studied—Iowa, Minnesota, Nebraska, and North Dakota—local governments would need additional revenues of from $30 to $45 per capita to hold services at 1982 levels. Under the more extreme assumption of a 25 percent cut in property tax receipts, the estimated shortfalls were two and one half times greater, ranging from $33 to 199 per capita.

On a per capita basis the revenues lost through reduced property taxes do not seem large compared to existing spending levels—even under the extreme assumption of a 25 percent drop in property tax collections. But, it is difficult to translate those dollars into actual losses of services. Cuts of that magnitude would move spending levels in the Iowa, Nebraska, and North Dakota study areas to 70 percent or less of national averages, joining localities in the Arkansas and Missouri counties studied at those relatively low spending levels.

The Additional Impact of Cuts in Intergovernmental Aids

Falling farm land values are not the most serious threat to local government revenues in all communities. In the Arkansas counties examined, eliminating Federal revenue sharing would reduce local spending, other things equal, by more than a 10 per cent drop in property tax receipts. In four other States a ten percent cut in State aid would have a larger impact.

The combined impact of cuts in Federal and State aid and the local property tax base under two alternative sets of assumptions is shown in figure 18. The low estimate is based on an assumed 10 percent drop in property taxes, a 50 percent cut in general revenue sharing, and a 20 percent cut in other Federal aids from 1982 levels. The high estimate assumes a 25 percent drop in property tax receipts, elimination of general revenue sharing, a 50 percent cut in other Federal aid and a 10 percent drop in State aid.

Again, these percentage cutbacks, while arbitrary provide realistic limits to the expected local government revenue losses. Impacts are based on revenues and expenditures reported in 1982, and several States have been forced to institute cutbacks of 10 percent or more since that time due to lagging State economies. At the Federal level general revenue sharing is scheduled for elimination at the end of the 1986 fiscal year, and Gramm-Rudman provisions are likely to force a further reduction in the real buying power of Federal aid between now and 1990. In addition, since the data used are 1982, sizeable decreases in the real value of these aids have already been observed.

The combined impacts of all potential cuts indicate major financial problems for rural communities. In all but Arkansas and Missouri the deficit under the low impact scenario totals more than $50 per capita, or $200 for a family of four. Under the high impact scenario the projected deficits were at least $100 in all but Missouri ($98.80). In the sparsely populated regions of Montana and Kansas, the deficits were more than $250 per capita. The lesson is clear. Any reduction in revenues will cause problems for local government, but when likely cuts from several sources are combined rural localities will face major financial problems.

Projected per capita shortfalls, based on 1982 levels of expenditures and revenues are shown in Table 3 and figure 19 for a ten percent cut in local property tax revenue and State aid, a 50 percent drop in Federal aid, and elimination of general revenue sharing. In this scenario, local property tax rates would need to increase enough to provide an average of $106 per capita, or $425 for a family of four, if cuts in services were to be avoided. Even if half that deficit were made up through local tax increases, local spending would still drop by more than $50 per capita.

TABLE 3.—LOCAL GOVERNMENT EXPENDITURE SHORTFALLS CREATED BY SELECTED CUTS IN PROPERTY TAX RECEIPTS, AND STATE AND FEDERAL AIDS SELECTED CROP REPORTING DISTRICTS, 1982

[Dollars per capita]

	Property Tax Sharing	General State Aid	Federal Aid	General Revenue	Total
Arkansas 6	13.02	35.77	13.73	23.49	86.01
Iowa 1	44.51	36.93	15.81	22.55	119.80
Kansas 3	79.62	25.27	7.31	21.23	133.43
Minnesota 7	31.92	64.43	7.75	28.03	132.13
Missouri 2	19.72	21.56	9.70	18.24	69.22
Montana 3	71.78	27.91	23.44	25.06	148.19
Nebraska 3	38.87	25.29	10.40	21.69	96.25
North Dakota 9	34.31	44.47	7.84	27.78	114.40

Assumes 10 percent cut in property tax receipts, 10 percent cut in State aid, 50 percent cut in Federal aid, and elimination of general revenue sharing.

In general, this research does not offer strong support to assertions that declining farm land values will create a financial disaster for rural local governments. Even under the extreme assumption that property tax collections would drop by 25 percent from their 1982 levels with no compensating aid increase, local revenues fell by only 12 percent or less in the regions studied. For school districts, as indicated earlier, State school foundation programs certainly will provide a cushion by automatically increasing aid. Real cuts in local expenditures may be necessary, but predictions of wholesale disaster for rural local government seem excessive.

There is still reason for concern, however. Rural communities may well be able to weather the loss in revenues associated with lower agricultural land values if that is the only drop in revenues. But, when coupled with likely cutbacks in Federal aid programs and the proposed elimination of general revenue sharing, the combined impact may be substantial. If there are also reductions in State aid—due to existing tight budget situations at the State level—rural local governments could well be in serious trouble. The cause, however, is not the farm crisis, or Federal budget cuts, or State financial problems, but rather the fact that each of these problems eventually results in fewer funds available for essential local government services. Individually any one of these problems might be overcome, but combined, their impacts may overwhelm the capacity of those governments most vulnerable.

LONG TERM EFFECTS

Declining farm property values and reductions in Federal and State aids appear likely to force cutbacks in local public services in many rural communities. Local milage rates will increase so that a higher proportion of local income goes to the public sector, but revenue shortfalls are likely to be so large that expenditure reductions will be necessary. In the absence of new State or Federal initiatives fewer, and lower quality public services will be available in rural areas.

Problems will be most severe in the nation's agriculturally dependent counties. (figure 20) These counties, and particularly those in America's heartland, have seen the largest declines in land values. The economies of several of the States where impacts have been greatest are also among those more heavily dependent on agriculture, so additional amounts of State assistance is less likely.

Historically, residents of most of these communities have taxed themselves at or above the national average in order to provide local public services. Reeder, in a study of local revenue efforts based on 1977 data, found many of these agriculturally dependent counties with revenue efforts at or above the average for nonmetro counties. (figure 21) A number of these counties had both high revenue efforts and rapidly increasing revenues. Since farm incomes have dropped substantially since 1977, a study of revenue effort today would likely include most counties with large declines in land values among those with high revenue efforts.

In keeping with their relatively high local tax effort, levels of public services in the agriculturally dependent counties outside the south have not been inadequate. Stinson (1983), examining trends in local service provision from 1962 to 1977, found that few of the counties whose spending for services was below that needed to provide minimally adequate education and other general public services were located in areas most heavily impacted by the current decline in farm incomes.

That study also showed that America has made significant progress toward insuring that both rural and urban residents have access to minimally adequate levels of publicly provided goods and services such as education. If the farm financial crisis and the attendant loss in local property tax base makes it impossible for farm based economies to continue to fund local government at the levels necessary to provide minimally adequate services, the nation risks moving backward, increasing the social and economic disparities between rural and urban America. Should that occur, rural residents would become an increasingly disadvantaged portion of society.

POLICY OPTIONS

The fiscal problems confronting rural local governments are both immediate and long term. In the short run, the rapid increase in property tax delinquencies will cause the most difficulty. The financial stress from the resulting cash flow problems may be further exacerbated by reductions in Federal and State aid.

Longer term, the dramatic declines in farm land values threaten the fiscal stability of many rural localities. Agricultural assessed values have only begun to reflect the steep drops in market values observed during the last few years, but the local property tax base will soon start to decline barring an unforeseen and unlikely increase in the market value of farm land. The farm crisis also will affect local commercial property values. In agriculturally dependent communities prolonged declines in farm income ultimately translate into reduced income and employment for the local business community. Lower commercial property values and declining property tax revenues soon follow.

Action by all levels of government is needed to ease the growing financial squeeze on rural local government. Creative solutions will be required because many of standard responses may be unfeasible, impractical or counterproductive. Local governments, for example, conceivably could raise property tax rates to compensate for looming declines in assessed valuations. But, this solution is unavailable in many communities. State-imposed caps on local tax rates, constitutional constraints, or other legal restrictions often limit a locality's ability to raise additional revenues. Communities which do not have statutory limits still must make a difficult choice—and face likely taxpayer resistance—if they attempt to raise taxes at a time when taxpayers' income and wealth have declined appreciably.

Similarly, most fiscally distressed local communities would ordinarily be expected to turn to their States for assistance in coping with difficult times. Yet the majority of States examined in this study also are under fiscal stress and reducing their own budgets. This is especially true for States with undiversified economies and those where additional economic problems stemming from the rapid fall in oil prices are likely.

Responses to Short Term Problems—Property Tax Delinquencies

The most serious short term problems stem from unanticipated revenue shortfalls caused by increases in property tax delinquency rates. As the data on the eight crop reporting districts makes clear, there is substantial local variation in delinquency rates. But, even when delinquency rates are relatively high, local governments can anticipate and adapt to the resulting revenue shortfalls if the percent delinquent has remained relatively constant over time.

Rapid increases in property tax delinquency rates over a short period of time, and the accompanying unexpected revenue losses create a more serious problem. In Nebraska, for example, delinquency rates rocketed from a stable, long-term rate of approximately 2 percent of collections in 1980 to nearly 10 percent in 1984. Moreover, the rate of increase was still accelerating in the most recent years for which data is available. Delinquency rates approximately doubled between 1982 and 1984, and then doubled again in 1985.

Less dramatic, but substantial increases in delinquency rates have also occurred in Minnesota. There the percent of property taxes delinquent more than doubled between 1982 and 1985. Between 1985 and 1986 delinquencies again showed a sharp increase. As in Nebraska, the largest increase occurred in the last year for which data is available. Iowa, Kansas and Montana have also seen abrupt increases in delinquency rates during the past two years.

In general, economists consider delinquent taxes to be a short term, cash flow problem for local government because most delinquent taxes will eventually be paid. During the depression farm properties were sold for back taxes, but today's tax levies remain small compared to the value of the property, even at current farm land values. The short term revenue shortfalls are an important problem for local government, however, especially in States like Nebraska which rely heavily on the property tax to finance local government services. In the Nebraska counties surveyed, 1985 delinquent taxes totalled more than $5.5 million, or about 4 percent of local revenues.

There are four principal methods for dealing with tax delinquencies:

- —permitting localities to adjust property tax levies upward in anticipation of delinquent collections;
- —insuring that penalties and collection procedures are such that taxpayers do not find that falling delinquent on property taxes is advantageous relative to other loan obligations;
- —instituting governmental efficiencies which enable local revenues to be used more efficiently.
- —obtaining additional nonproperty tax sources of revenue such as intergovernmental aid.

The first three options fall within the province of State and local responsibilities, while the fourth option involves Federal policies as well.

Delinquency anticipation and penalty Provisions—Most local governments have already exhausted these local options for dealing with property tax delinquencies, although some individual jurisdictions could do more. Either by custom or by law, most States already permit localities to adjust their tax levies in anticipation of delinquent taxes. Local governments in each of the eight farm belt States surveyed are allowed to levy taxes at higher rates in anticipation of delinquencies, to consider prior delinquency rates in planning revenues, or both. (table 4) In addition, some States allow local governments to carry a cash reserve over from one year to the next.

The usefulness of these provisions is limited by two factors. First, revenues raised by anticipating delinquencies at the prior year's rate will be insufficient when delinquencies are rising rapidly. North Dakota, for example, permits additional levies of 5 percent in anticipation of delinquent taxes. But, some North Dakota counties have had delinquencies averaging 10 percent or more of the total tax levy recently. Second, communities are often unable to utilize delinquency anticipation levies because local tax rates have reached statutory levy limits. One municipal bond advisory group estimates that "a substantial majority of local jurisdictions [in the farm belt] are taxing at their limits, especially school districts." (American Portfolio Advisory Service)

TABLE 4.—PROPERTY TAX DELINQUENCY AND PENALTY PROVISIONS, SELECTED STATES

State	Anticipate prior year delinquent tax rate	Anticipate additional delinquent taxes	Reserve fund	Penalty provision
Arkansas	X		X	10% penalty 10% interest
Iowa	X			1% /month
Kansas	X	X		1½% /month
Minnesota		X	X	10% penalty +8% interest
Missouri			X	18% per annum 2% penalty
Montana		X		5/6% /month 2% penalty
Nebraska	X	X	X	14% /annum
North Dakota		X		3% /quarter 5% bonus for early payment

Governments may also minimize delinquencies by making sure that penalties are sufficiently high, relative to interest charged on farm and commercial loans, to make letting property taxes go unpaid an unattractive alternative. This is generally the case in the States examined. At present, interest plus penalities are substantially above current interest rates in all States but Iowa and Montana. Officials in Iowa attribute at least part of the higher delinquency rates recently observed to the sizeable spread between interest rates from commercial lenders and the interest and penalties on delinquent taxes.

Cutback management—Local governments can also try to stretch reduced local revenues farther by introducing management efficiencies. Cutback management techniques such as banding together with other jurisdictions to deliver some specialized services, and contracting with private firms for others have become increasingly popular suggestions for local governments in recent years.

Such strategies may offer savings for certain rural governments. One study notes that non-metropolitan cities engaged in only two-thirds as many joint service arrangements as did metropolitan cities. (ACIR, 1985) On the other hand, non-metro counties are just as active in utilizing such efficiency techniques as metro counties. There also are reasons to believe that many rural governments face unique problems in realizing saving from contracting for services and alternative structural arrangements. Small communities and sparsely populated rural areas offer small potential markets for private service contractors. In addition, most already utilize volunteerism and informal service arrangements very heavily.

Structural consolidations also have been utilized heavily by rural governments, and the available cost savings may have been exhausted in most areas. School consolidation, the most common example, is largely complete. The number of school districts in the United States has declined dramatically in the last 40 years, from a total of 108,579 in 1942 to just 14,851 in 1982. Almost all of this decline has taken place as a result of consolidating small rural districts. The rate of change has slowed drastically in the last decade, however, suggesting that most districts have reached their geographic limits. The number of districts declined 48 percent between 1952 and 1962; 54 percent between 1962 and 1972; but only 6 percent between 1972 and 1982.

The revenue expenditure squeeze on the local public sector will be less severe if significant numbers of farm families leave to take jobs in the urban centers. But, as Hines, Green, and Petrulis (1985) note, the current restructuring of agriculture may be accompanied by a change of ownership of many existing farms rather than a substantial decline in the total number of farms. Those facing the greatest financial difficulty today are those classed as medium sized, commercial farmers. The more than one-half of all farmers receiving less than $40,000 in gross receipts from the sale of agricultural commodities (and thus are considered to have off-farm sources of income to support their families) generally are having fewer financial problems.

Research done on South Dakota rural governments reinforces the conclusion that further structural efficiencies are limited. In 1957, South Dakota had 7.5 local governments per 1,000 population, ten times the national average of .76. By 1967 this number had fallen to 5.3, and by 1977 it reached 2.6. Since 1977 it has remained constant to 2.6, even though the national average has continued to fall. (Smith) That research also indicates that for counties under 15,000 in population, there is an inverse relationship between county population and the average per capita cost of government, again suggesting that in many communities, small populations and large territories impose unique constraints on governmental costs and efficiencies which cannot be eliminated through management techniques or structural changes. These constraints may explain why relatively small drops in revenues produced such painful service cutbacks in the earlier case studies of Fulda, Minnesota and School District 417.

State and Federal aid.—A final option for dealing with the fiscal effects of unexpected tax delinquencies is to cushion those impacts with increased State or Federal aid. Unfortunately, severe budgetary stress at the Federal level and in many States is actually compounding local revenue shortfalls rather than alleviating them. In all but one of the States in our sample revenues grew more slowly than the national average in fiscal 1985, 1986 or both. Four of these States experienced absolute declines in revenues. As a result, six of the eight States examined took the extreme step of making mid-year reductions in their fiscal 1986 budget after it had already been adopted. Five States reduced State aid to education.

Federal aid reductions also compound the effects of tax delinquencies. Between 1982 and 1984, total Federal aid to general purpose local governments, not including General Revenue Sharing, rose .1 percent nationwide in current dollars. In the agriculturally dependent counties examined in this study, however, Federal aid actually declined 18 percent during this same period. Although individual jurisdictions varied in the amount of Federal aid received, agriculturally dependent local governments experienced declines in Federal aid in five of the eight States examined—in sharp contrast to the overall rise nationwide.

This decline in Federal aid at a time of severe economic distress takes on added significance given the scheduled phase-out of General Revenue Sharing at the end of the 1986 fiscal year. Elimination of revenue sharing, without some form of replacement, will have a far more serious impact on general purpose governments in agriculturally-dependent areas than on those in urban areas. Revenue sharing comprised, on average, 44.5 percent of all Federal aid received by general purpose local governments in farm dependent areas, compared with a national average of 21.8 percent for all general purpose local governments. Thus, the proposed elimination of General Revenue Sharing will hit farm dependent local governments twice as hard as the average locality in America, compounding the steep declines in taxable valuations in rural areas and the effects of prior Federal aid reductions.

Responses to the Long-Term Problem

Short term, cash flow problems of local government can be eased if the policy actions reviewed are taken, but such activities can do little to redress the longer term imbalances and development needs in distressed rural communities. Many of the potential programs which address the economic development needs of rural communities—such as farm income and credit programs and industrial policies—are outside the intergovernmental focus of this study. But, Federal and State programs to insure the existence of the basic infrastructure required for development and those programs which enable rural communities to provide basic services and address their own economic development needs require consideration. At the State level, such policies include diversified revenue systems and local property tax relief, especially for education. At the Federal level, such policies center on provisions of the tax code that encourage rural governments to address their individual infrastructure needs.

State revenue systems—Local government revenues and service levels cannot be considered in isolation. Even where the impact of falling land values is fully transmitted through property tax assessments the severity of this devaluation will depend on the importance of the property tax as a percentage of total local revenues.

Local governments' reliance on the property tax typically is inversely related to the level of State aid available. State aids can act as a compensatory buffer protecting local government revenues from abrupt changes in the local economy. As illustrated earlier the eight States sampled varied significantly in the amount of financial assistance provided localities. In North Dakota, for example, State aid was 41 percent of all local, general revenues in 1982—well above the national average of 32.7 percent. In Nebraska, on the other hand, total State aid to local governments was only 20.6 percent of local general revenues—about half that in nearby North Dakota and almost 40 percent below the national mean.

Overall levels of State aid are important, but two related factors must also be considered. First, even within States there are significant variations in the relative amounts of State aid received, both for different functions and for different types of local government. In addition, State aid levels over time are dependent on the overall health of the State's budget and economy. High levels of dependence on State aid levels may be a mixed blessing if aid is cut back due to State budgetary constraints.

State revenue sources usually are more sensitive to changes in economic conditions than is the property tax, and this can be a significant problem. States attempt to minimize this risk, however, by diversifying and broadening their tax base. There is a tradeoff, however, since a stable tax base, one which does not fluctuate with economic conditions, typically creates a regressive tax system.

Federal policies—Current Federal budget constraints limit the amount of direct Federal assistance likely to be available to rural communities. In the near future, changes in Federal tax policy could have more substantial impacts on the ability of rural communities to address their long term needs than will budget cutbacks. Two elements of the Federal revenue code are of particular importance—the Federal income tax deduction for State and local income, sales, and property taxes; and the exemption of interest from State and local government bonds.

The deduction for State and local taxes cuts the effective costs of such taxes to the individual taxpayer, providing the same income tax treatment for money paid to State and local government as is afforded contributions to charity. No preferential treatment is given to particular State or local tax instrument. No attempt is made to determine which services should be provided by which level of government, and no implicit or explicit Federal mandates are imposed on State or local governments. The deductibility of State and local taxes simply provides a constitutionally preferred method by which the national government can assist its intergovernmental partners in addressing their own, unique public service needs.

The importance of deductibility can best be appreciated by estimating the effects of its elimination on State and local government spending. Several recent proposals for tax reform have advocated eliminating the deduction for State and local taxes in order to provide revenues for lowering overall tax rates. Estimates vary widely, but the congressional Research Service has calculated that the long term impact of eliminating deductibility would reduce State and local revenues 20.5 percent below what they would otherwise be. Other estimates are smaller, in part because some analysts predict shifts in State-local taxes to forms that would remain deductible, such as taxes on business. (Feldstein and Metcalf)

Coming on top of the revenue squeeze resulting from the farm crisis, elimination of deductibility would profoundly restrict the capacity of State and local governments to meet long term rural development needs. The impact would be particularly severe in agriculturally dependent States, because residents of these States would receive fewer net benefits from tax rate reductions. Taxpayers in the ten States where agricultural production is greatest would, on average, benefit 4 percent less than the average taxpayer from President Reagan's tax reform plan. Residents of the 8 States examined in this study would benefit an average of 10 percent less than the average taxpayer. (ACIR, 1986)

Tax exempt bonds—While deductibility encourages State and local governments to address their overall public service needs, the tax exempt treatment of municipal bonds provides direct financial support for public infrastructure investments, laying a foundation for the diversification of rural economies. In 1982, for example, a total of $87.5 billion in tax exempt bonds were issued to finance a wide range of traditional public facilities and newer forms of public-private partnerships. Sixteen billion dollars went to finance school construction, transportation projects, and water and sewer facilities. An additional $12.7 billion in industrial revenue bonds was used to finance commercial and industrial development projects. All told, the proceeds of tax exempt bonds comprised an average of 47 percent of all State and local capital expenditures between 1980 and 1984.

Despite their importance to all local communities, the tax exempt status of many municipal bonds has been threatened. Proposed changes in Federal tax law would reduce the total issuance of bonds by 40 to 70 percent. In addition, many provisions of particular importance to the bonds offered by rural communities are proposed for elimination. The elimination of small issue industrial development bonds (IDB's) which fund "aggie bonds" providing start up capital for first-time farms, and the limitation of public-private partnerships financed by tax exempt bonds are two examples of the types of provisions under attack.

The House-passed tax reform bill also imposes major limits on bonds benefiting rural communities, including elimination of the bank interest deduction for purchasing small issue IDB's; the retroactive elimination of tax exempt status for violations of arbitrage provisions; restrictions on the use of tax increment financing; and restrictions on yields from investments during project construction periods.

Eliminating the bank interest deduction for small issue IDB's would destroy the market for most small communities. Small rural banks are virtually the only purchasers of such issuances, and this deduction is critical to make them a viable investment.

The retroactive penalty provision would also have its most severe impact on rural communities because it would raise interest costs on bonds and force communities to use high cost underwriters. Since 50 percent of the bonds currently issued by the most rural communities are unrated and carry above average interest rates, statutory changes which further increase those interest rates will pose particular problems for rural America. (Palumbo and Sachs, 1986).

Proposals to limit the use of tax increment financing for development areas 15 acres and above would restrict the use of such bonds to large urban areas since small communities rarely have blighted areas of such size.

Finally, restricting the yield local governments may earn on investments of bond proceeds during the period when public facilities are under construction increases financial burdens on small communities for their infrastructure projects. Communities reduce the costs of infrastructure by investing bond proceeds until needed to pay construction costs. Forcing localities to invest bond proceeds at reduced yields inevitably will force these governments to issue more bonds to finance the same projects. Because rural communities have weaker tax bases and pay higher average interest rates on bonds already, they will be among the governments most penalized by such proposals.

Targeted Fiscal Assistance

Adoption of a smaller, but better targetted program of general assistance grants to local governments is one possible Federal policy response. Such a program would help alleviate both short and long-run problems, while contributing to the reduction of the Federal deficit. The principle advantages of General Revenue Sharing—flexible, general purpose grants with little administrative overhead—would be retained, but benefits would be limited to those communities most in need.

The impact of a more tightly targeted revenue sharing program on revenues of the communities in this study is shown in table 5. That program's provisions are shown in Appendix D.

TABLE 5.—COMPARISON OF FUNDING LEVELS UNDER GENERAL REVENUE SHARING AND TARGETED FISCAL ASSISTANCE; COUNTY AVERAGES, SELECTED CROP REPORTING DISTRICTS

State	GRS Allocation (Dollar Per Capita)	TFA Allocation (Dollar Per Capita)	Percentage Change
Arkansas	6.25	13.41	112
Iowa	6.90	8.17	15
Kansas	8.62	8.84	2
Minnesota	9.30	13.17	39
Missouri	2.25	5.03	41
Montana	11.24	18.76	90
Nebraska	7.44	11.93	20

TABLE 5.—COMPARISON OF FUNDING LEVELS UNDER GENERAL REVENUE SHARING AND TARGETED FISCAL ASSISTANCE; COUNTY AVERAGES, SELECTED CROP REPORTING DISTRICTS—Continued

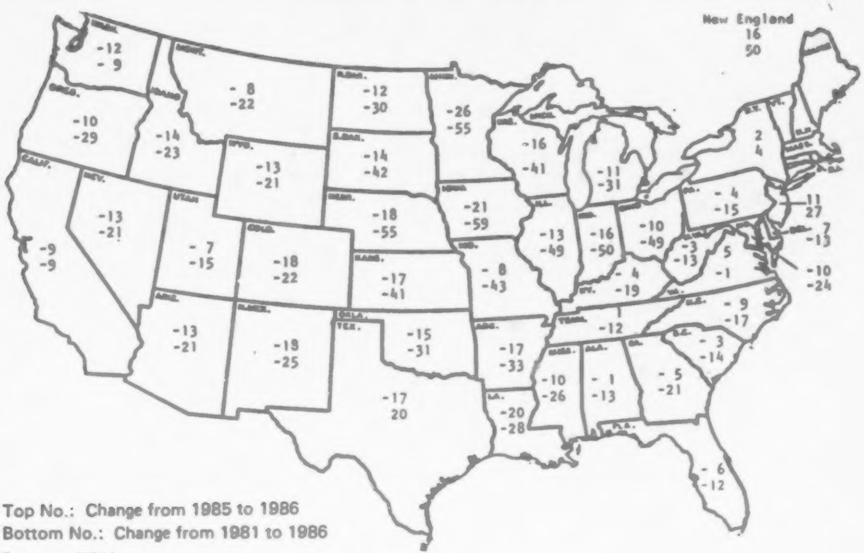
State	GRS Allocation (Dollar Per Capita)	TFA Allocation (Dollar Per Capita)	Percentage Change
North Dakota	9.04	13.31	43

In general, increased funds are directed toward poorer communities and those with above average tax effort. Usually such communities have levels of income substantially below the Statewide average. As a result, they would receive grants averaging 53 percent higher under targeted fiscal assistance. On the other hand, communities with per capita incomes substantially over their State average would receive reduced amounts of aid or, in some cases, no aid at all. This allows funds to be concentrated on communities most in need, enabling them to maintain a minimum level of basic public services.

CONCLUSION

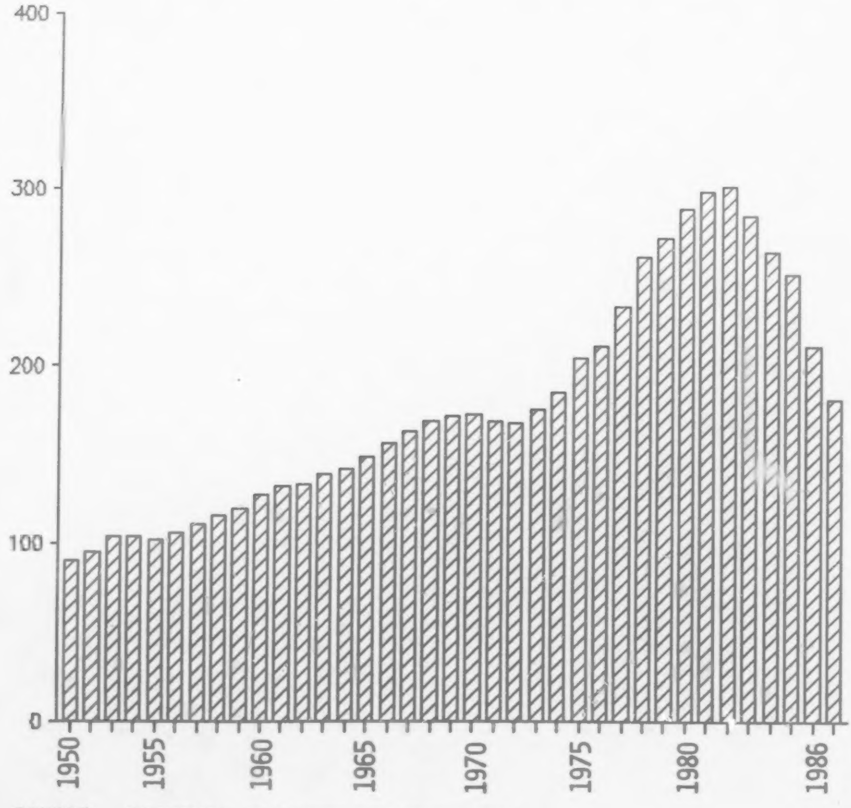
Many of the financial problems which will face rural local government can be limited if governments at all levels begin to respond now, before the full effects of declining land values and increased service demands are felt. State and local governments, must explore all available avenues of potential savings, seeking new ways to deliver basic services, and building on their economic strengths. The Federal Government must give affected State and local governments the time and the tools to respond. In particular, the Federal Government must avoid implementing those budget reductions and changes in the tax code that will compound the problems of rural governments. Federal actions must be designed to avoid making the situation worse at the very time rural localities are least able to cope with financial problems. Rural communities face unprecedented economic and social challenges as agriculture restructures and America enters its third century. The costs of assisting that transition pale when compared to those of ignoring it.

FIGURE 1: **Percent Change in Average Value of Farm Real Estate Per Acre**
April 1, 1985 - February 1, 1986 and
February 1, 1981 - February 1, 1986


-12
- 9
- 8
-22
-12
-30
-26
-55
-10
-29
-14
-23
-13
-21
-14
-42
-16
-41
-11
-31
New England
16
50
2
4
-13
-21
-7
-15
-18
-22
-18
-55
-21
-59
-13
-49
-16
-50
-10
-49
- 4
-15
11
27
7
-13
-9
-9
-3
-13
5
-1
-10
-24
- 8
-43
- 4
-19
-17
-41
-13
-21
-18
-25
-15
-31
-12
- 9
-17
-17
-33
- 3
-14
-10
-26
- 1
-13
- 5
-21
-17
20
-20
-28
- 6
-12

Top No.: Change from 1985 to 1986
Bottom No.: Change from 1981 to 1986
Source: USDA

FIGURE 2: INDEX OF REAL VALUE OF U.S. FARM LAND, 1950-1986.



SOURCE: ECONOMIC RESEARCH SERVICE, USDA.

FIGURE 3: CROP REPORTING DISTRICTS INCLUDED IN SURVEY OF RURAL LOCAL GOVERNMENT FINANCES

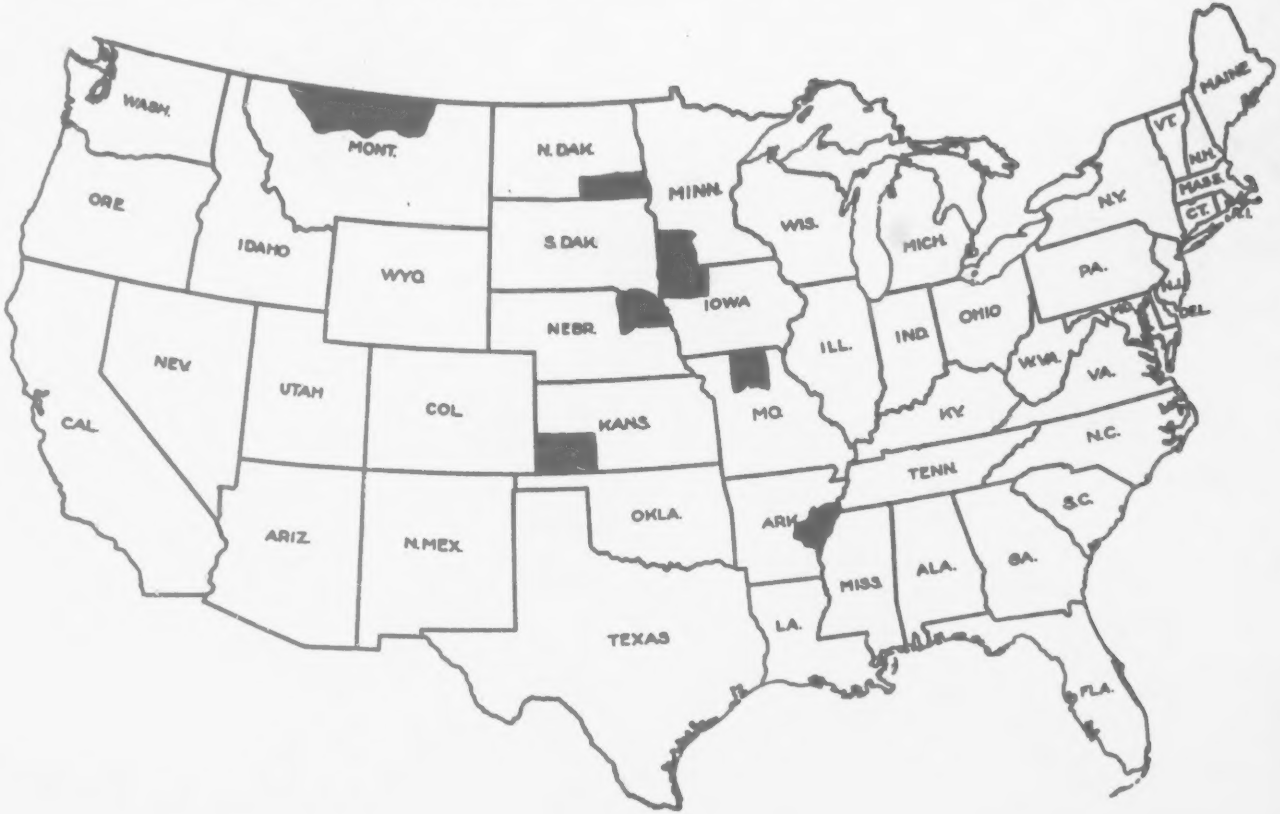

WASH.
ORE.
CAL.
NEV.
IDAHO
MONT.
WYO.
UTAH
ARIZ.
COL.
N.MEX.
N.DAK.
S.DAK.
NEBR.
KANS.
OKLA.
TEXAS
MINN.
IOWA
MO.
ARK.
LA.
WIS.
ILL.
MICH.
IND.
OHIO
KY.
TENN.
MISS.
ALA.
GA.
FLA.
S.C.
N.C.
VA.
W.VA.
MD.
DEL.
N.J.
PA.
N.Y.
VT.
N.H.
MAINE
MASS.
CT.

FIGURE 4:

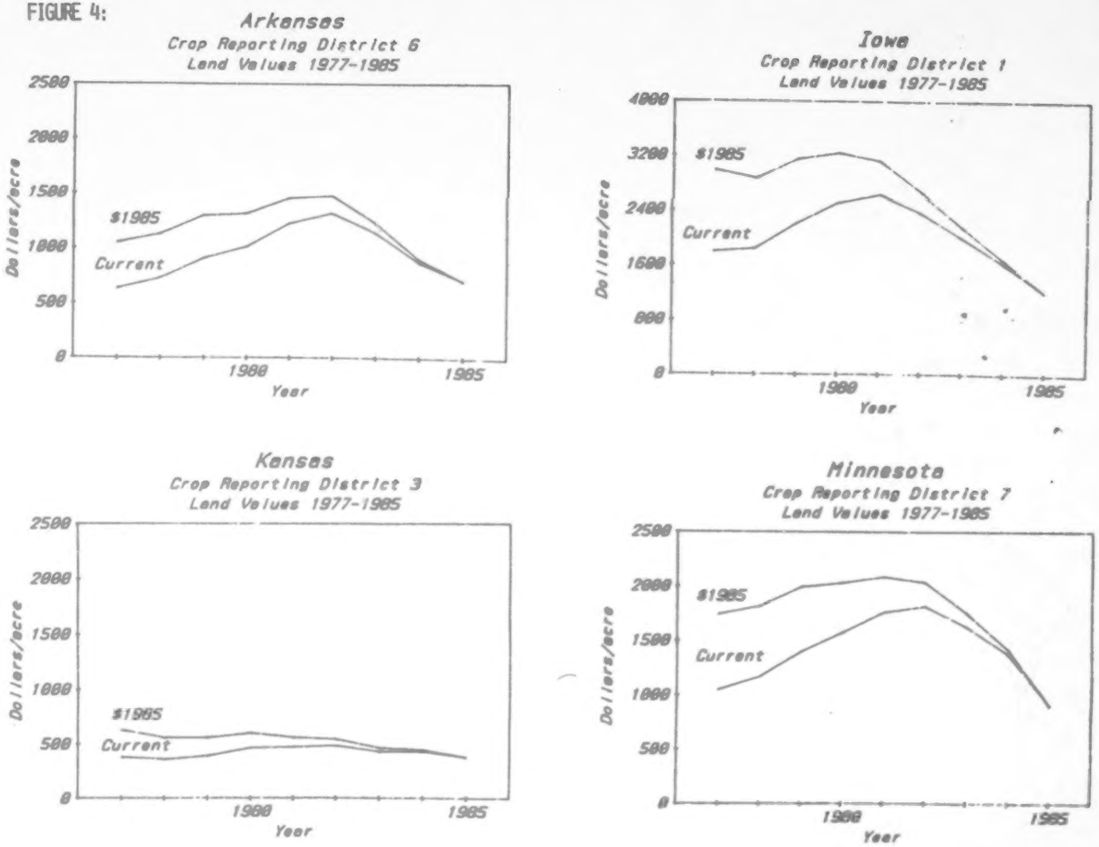
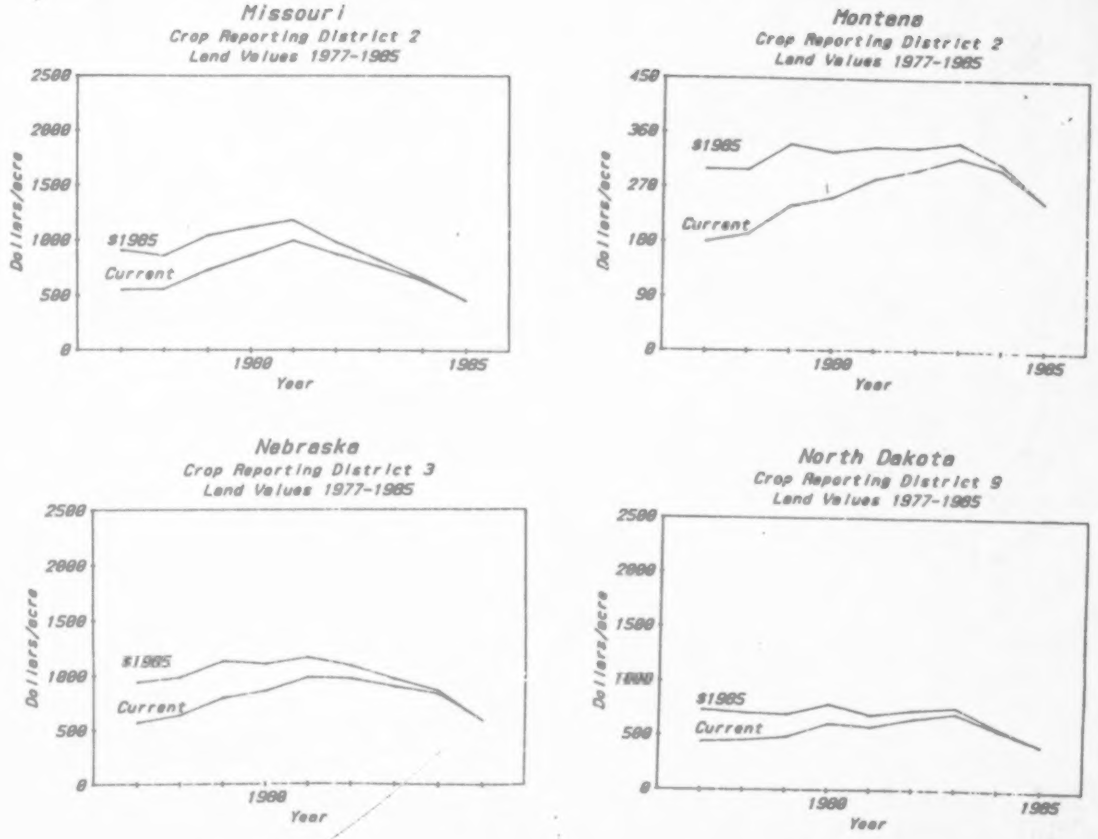

Arkansas
Crop Reporting District 6
Land Values 1977-1985
Dollars/acre
2500
2000
1500
1000
500
0
$1985
Current
1980
1985
Year
Iowa
Crop Reporting District 1
Land Values 1977-1985
Dollars/acre
4000
3200
2400
1600
800
0
$1985
Current
1980
1985
Year
Kansas
Crop Reporting District 3
Land Values 1977-1985
Dollars/acre
2500
2000
1500
1000
500
0
$1985
Current
1980
1985
Year
Minnesota
Crop Reporting District 7
Land Values 1977-1985
Dollars/acre
2500
2000
1500
1000
500
0
$1985
Current
1980
1985
Year

FIGURE 4:



Missouri
Crop Reporting District 2
Land Values 1977-1985

Montana
Crop Reporting District 2
Land Values 1977-1985

Nebraska
Crop Reporting District 3
Land Values 1977-1985

North Dakota
Crop Reporting District 9
Land Values 1977-1985

FIGURE 5: TAXABLE VALUE OF AGRICULTURAL LAND AS A PERCENTAGE OF TOTAL TAXABLE, VALUATION, SELECTED CROP REPORTING DISTRICTS, 1985.

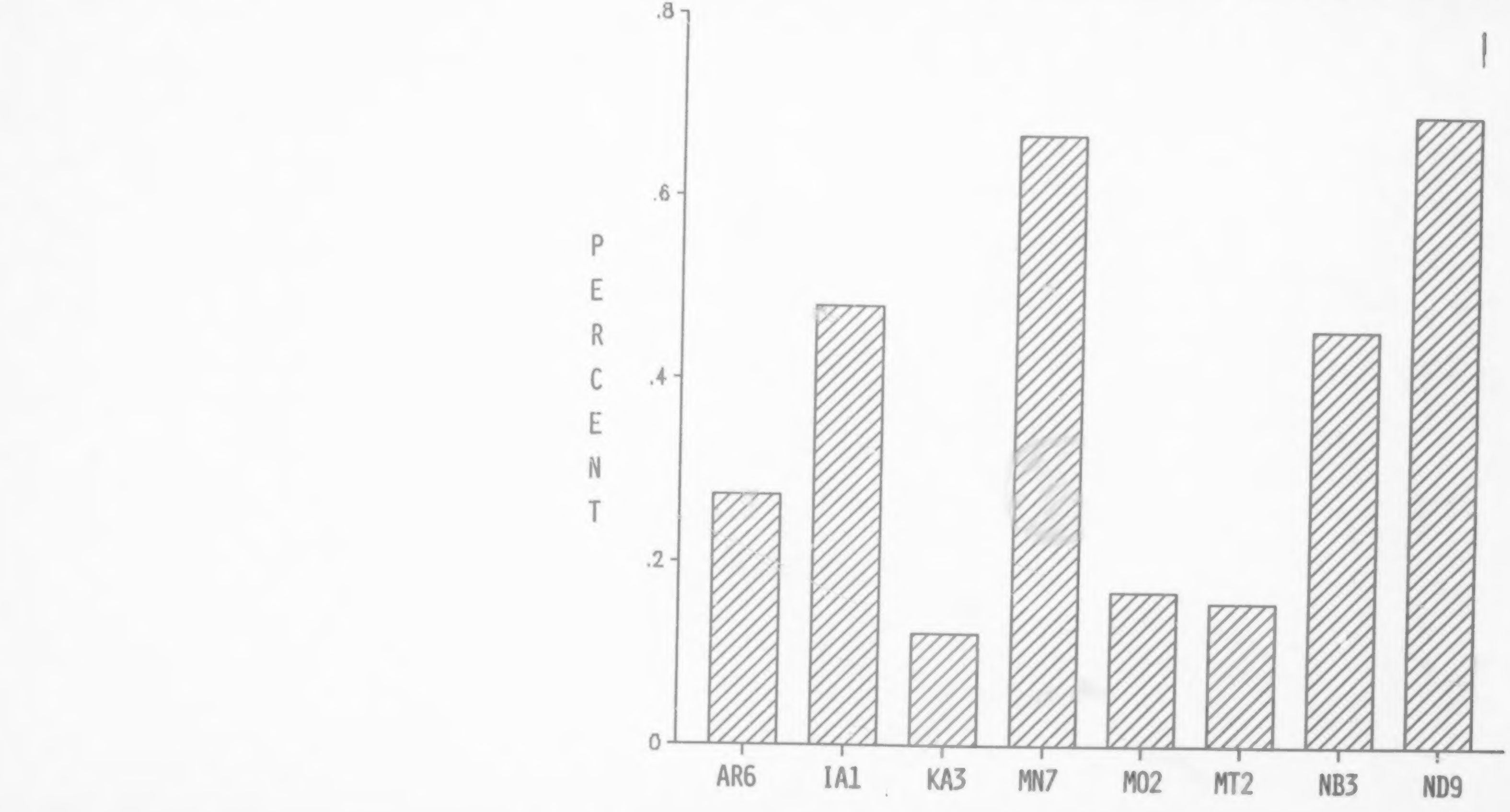
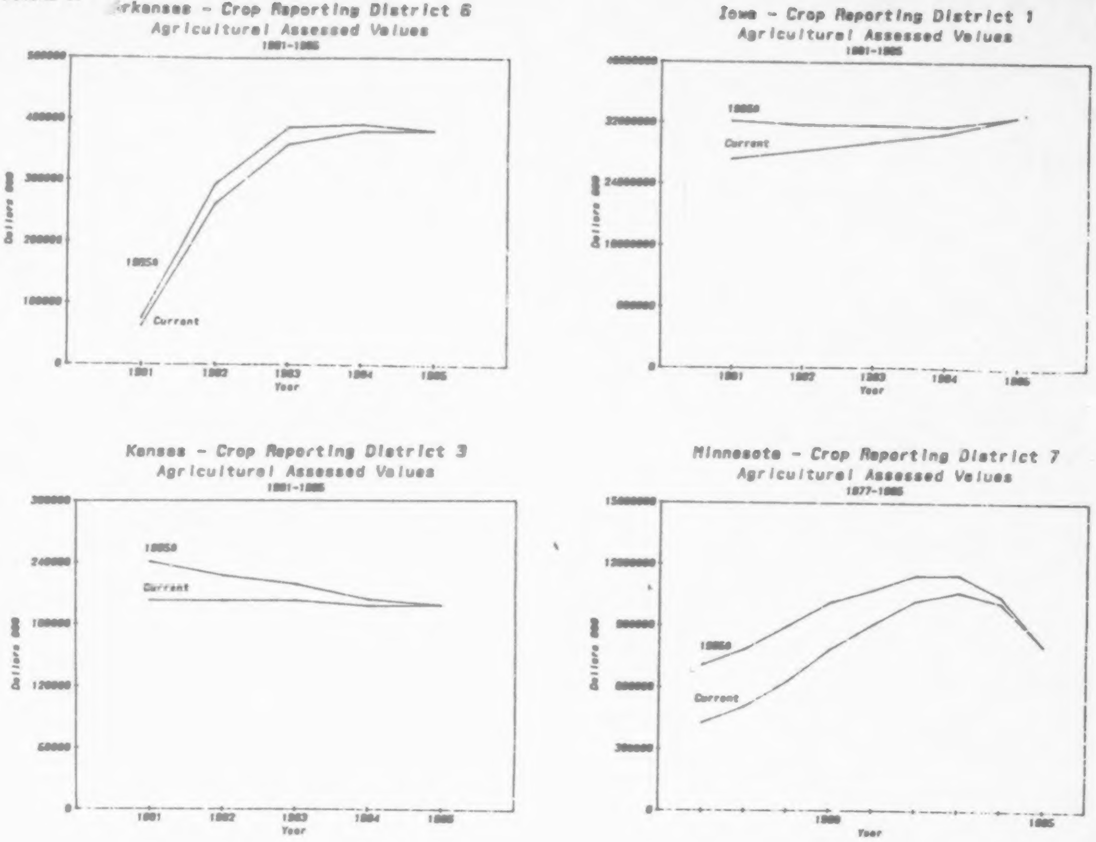


FIGURE 6:



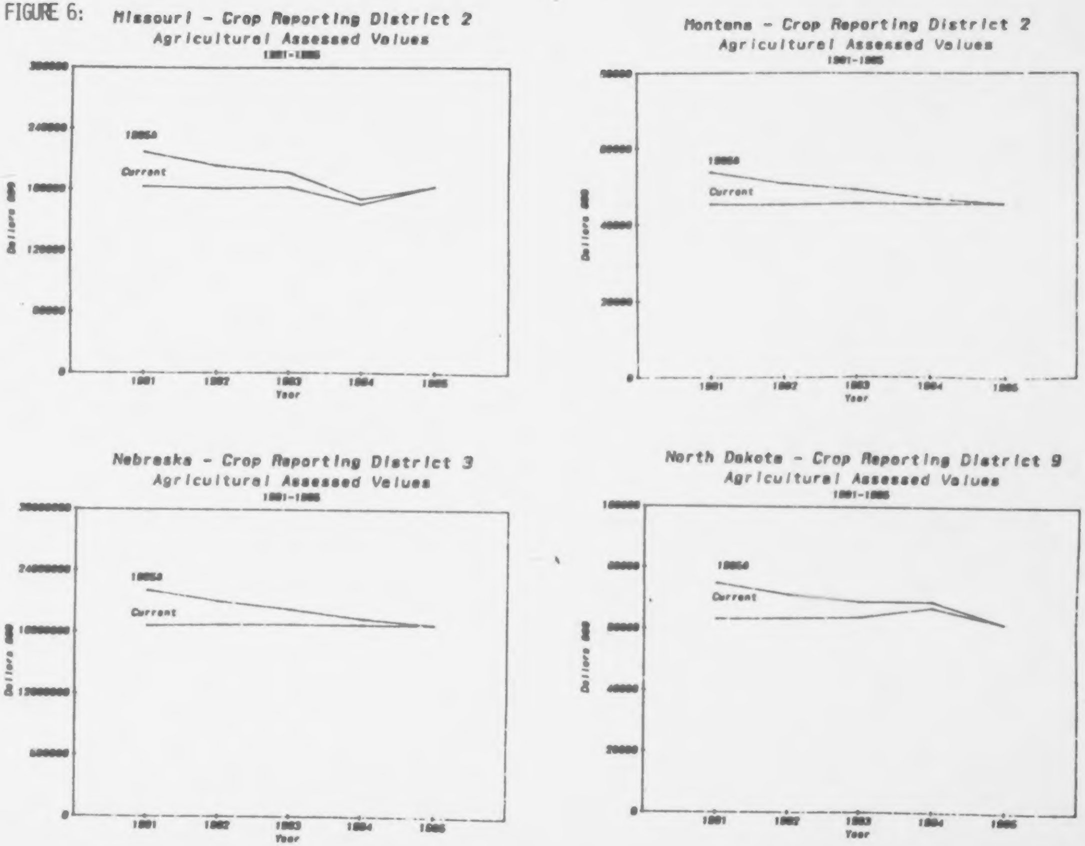
Arkansas - Crop Reporting District 6
Agricultural Assessed Values
1981-1985

Iowa - Crop Reporting District 1
Agricultural Assessed Values
1981-1985

Kansas - Crop Reporting District 3
Agricultural Assessed Values
1981-1985

Minnesota - Crop Reporting District 7
Agricultural Assessed Values
1977-1985

FIGURE 6:



Missouri - Crop Reporting District 2
Agricultural Assessed Values
1981-1985

Montana - Crop Reporting District 2
Agricultural Assessed Values
1981-1985

Nebraska - Crop Reporting District 3
Agricultural Assessed Values
1981-1985

North Dakota - Crop Reporting District 9
Agricultural Assessed Values
1981-1985

FIGURE 7: Assessment Procedures for Agricultural Land, Selected States, 1986.

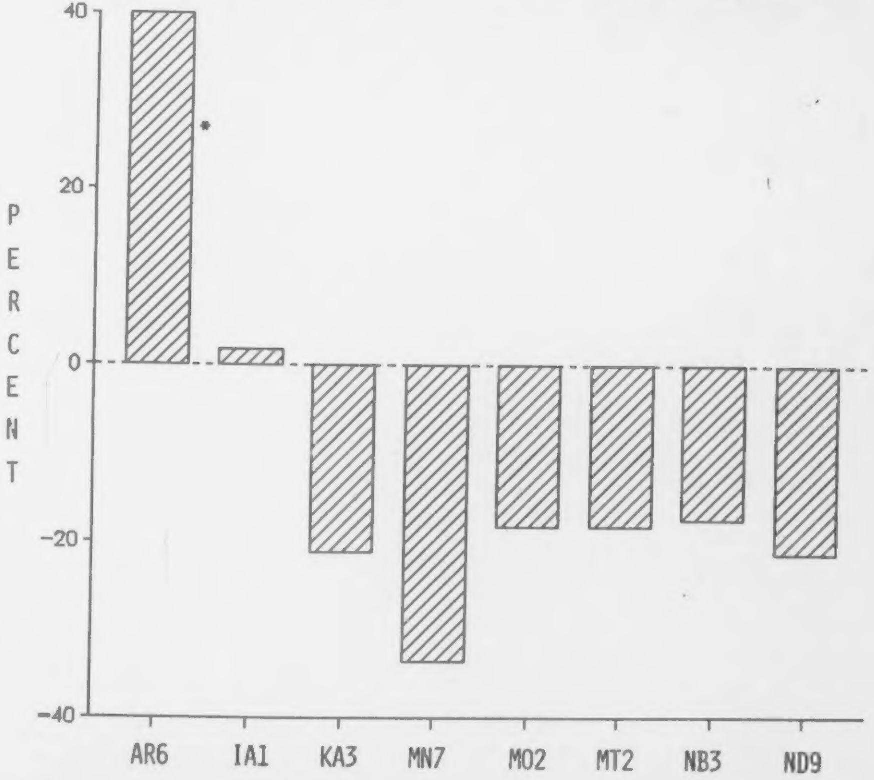
	BASIS	FORMULA VARIABLE	CAPITALIZATION RATE	TAXABLE VALUATION
Arkansas	Soil Productivity/Use	12-yr. (high & low yr. discarded) moving	10% .	20%
Iowa	Productivity	net income determined by 5-yr. moving avg. of production, prices, & expenses	7%	100% multiplied by a rollback percentage
Kansas	Mkt. Value		N/A	30% (2)
Minnesota	Mkt. Value		N/A	
Missouri	Productivity			12%
Montana (1)	Productivity	estimated from 1959 market data	Unchanged from original	30%
Nebraska	Productivity	net income determined by 5-yr. moving avg. of price & yield less experience factors.	11% for 1986	100%
North Dakota	Productivity	30% of 6 yr. moving avg. (high & low yr. discarded) of gross income.	12 yr. moving avg. (with high & low year discarded) of gross income.	Assessed value is 50% of true and full value. Taxable value is 10% of assessed value.

---

(1) Values have not changed since 1963. As future reappraisals warrant higher valuations, the percentage applied to determine taxable value will be lowered to keep values constant.

(2) Current valuations actually are about 8% of Mkt. value.

FIGURE 8: PERCENT CHANGE IN REAL ASSESSED VALUES OF AGRICULTURAL LAND, 1981-1985, SELECTED CROP REPORTING DISTRICTS



*STATEWIDE REASSESSMENT 1982-83.

FIGURE 9: DOLLAR VALUE OF PROPERTY TAXES DECLARED DELIQUENT IN 1985, SELECTED CROP REPORTING DISTRICTS

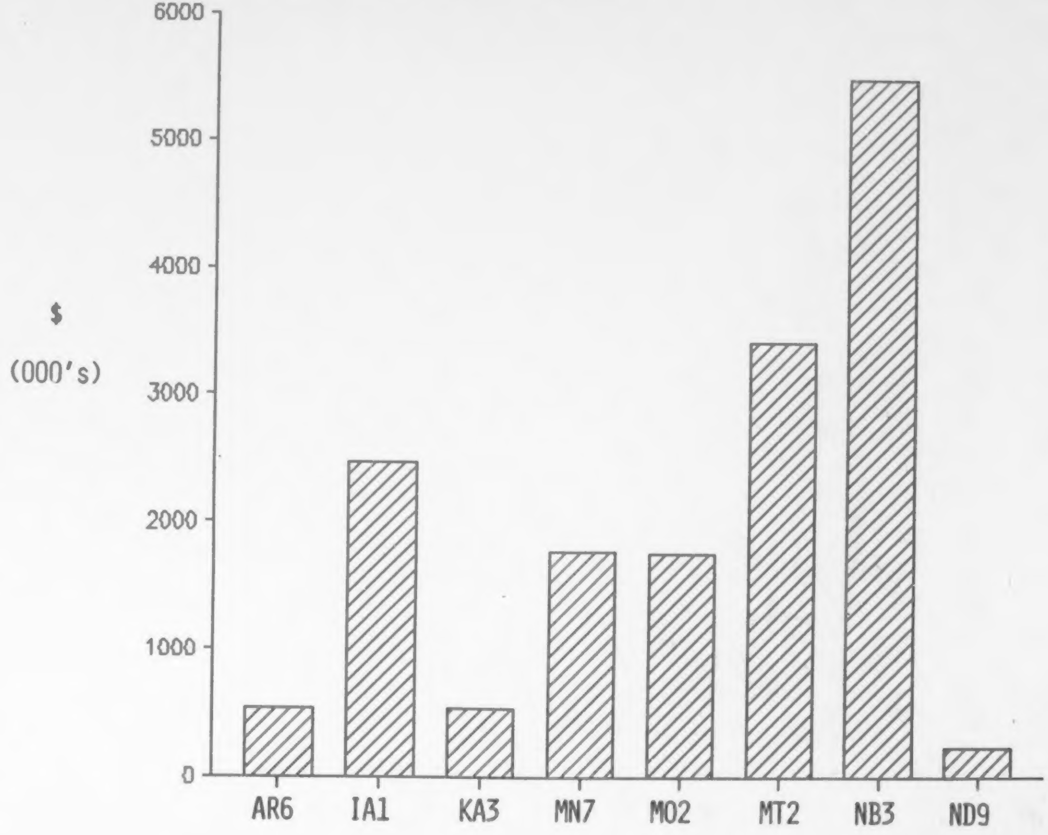


FIGURE 10: PERCENT CHANGE IN PROPERTY TAX DELINQUENCY RATE, SELECTED CROP REPORTING DISTRICTS, 1981-1985

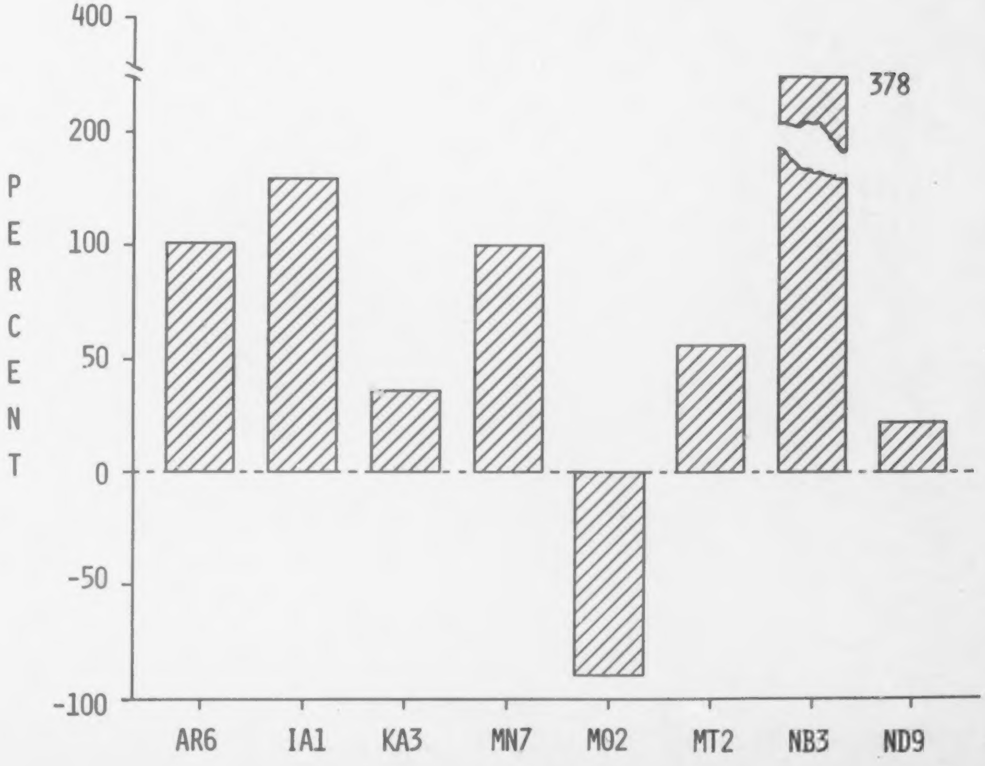
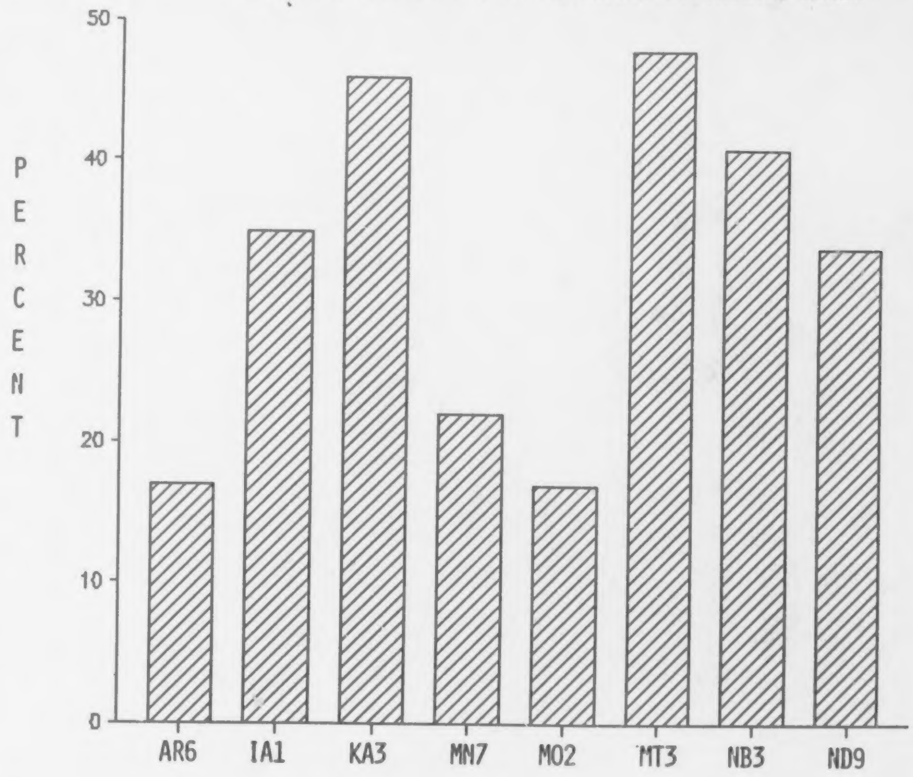
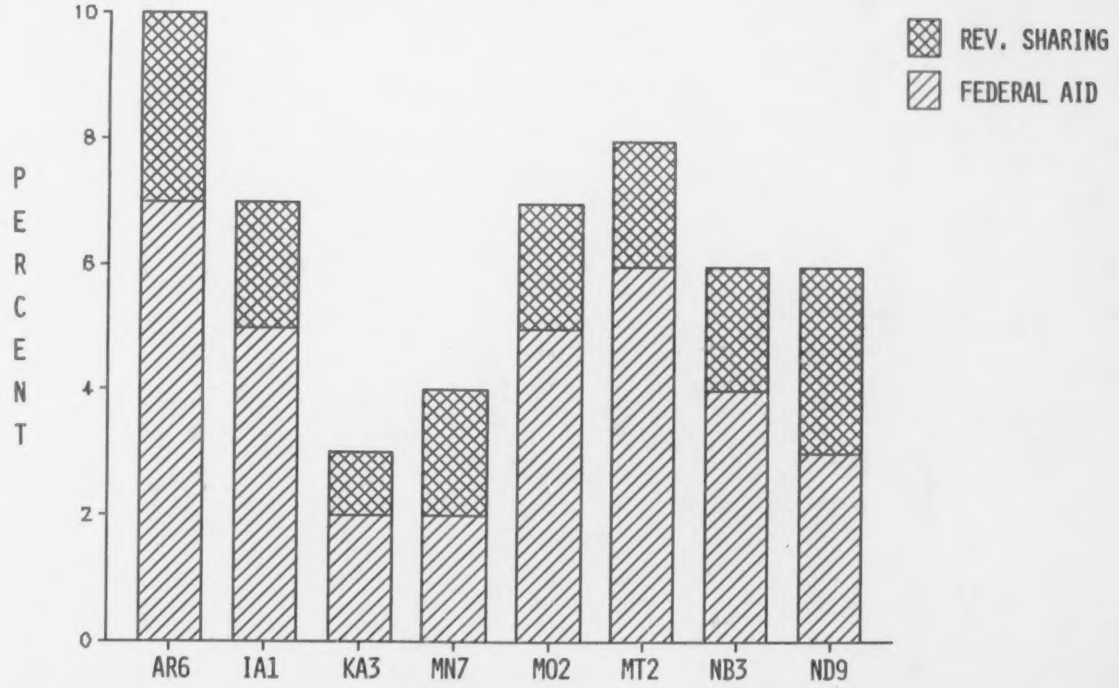


FIGURE 11: PROPERTY TAXES AS A PERCENTAGE OF LOCAL GOVERNMENT GENERAL REVENUES, SELECTED CROP REPORTING DISTRICTS, 1982.



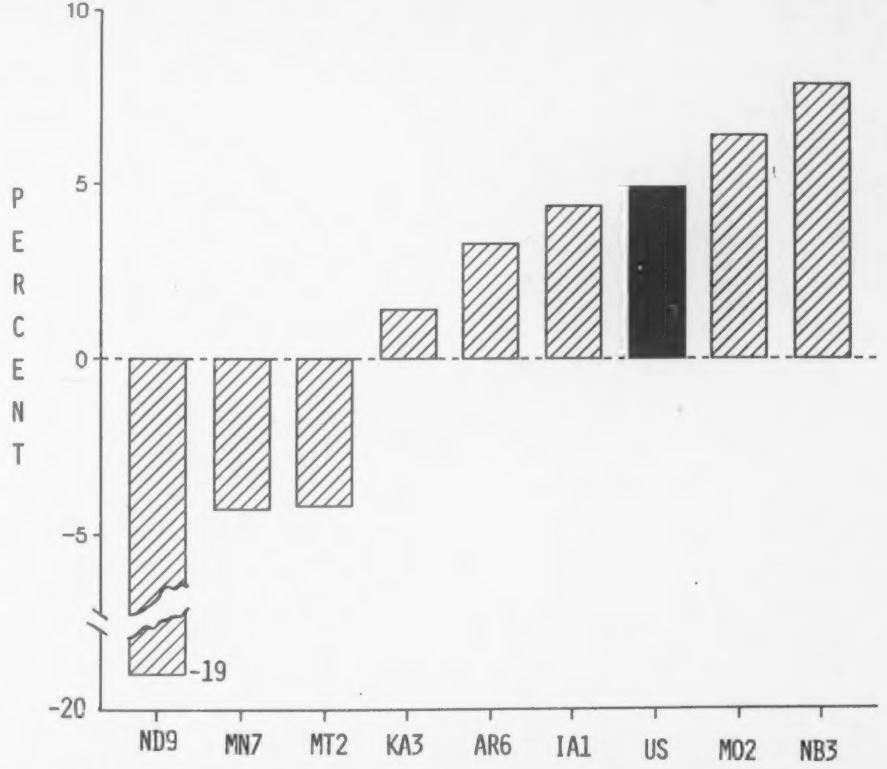
SOURCE: 1982 CENSUS OF GOVERNMENTS.

FIGURE 12: FEDERAL AID AS A PERCENTAGE OF LOCAL GOVERNMENT GENERAL REVENUES, SELECTED CROP REPORTING DISTRICTS, 1982.



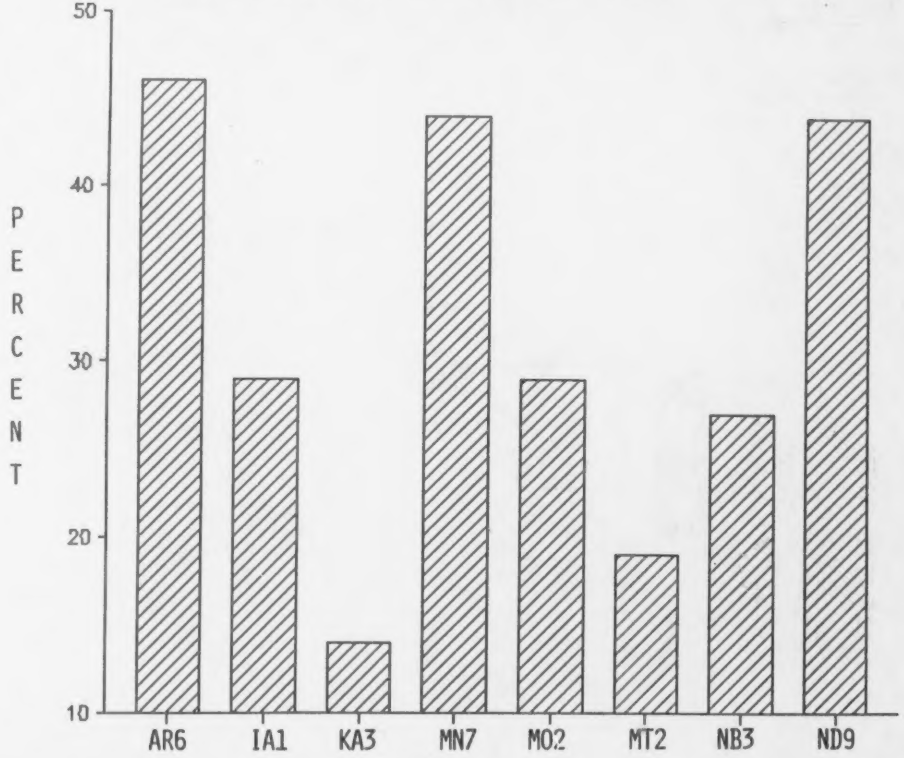
SOURCE: 1982 CENSUS OF GOVERNMENTS.

FIGURE 13: ESTIMATED CHANGES IN STATE GOVERNMENT REVENUES, 1985-1986.



SOURCE: ADVISORY COMMISSION ON INTERGOVERNMENTAL RELATIONS.

FIGURE 14: STATE AID AS A PERCENTAGE OF LOCAL GOVERNMENT GENERAL REVENUES, SELECTED CROP REPORTING DISTRICTS, 1982.



SOURCE: 1982 CENSUS OF GOVERNMENTS.

FIGURE 15: PER CAPITA OPERATING EXPENDITURES BY LOCAL GOVERNMENTS AS A PERCENT OF NATIONAL AVERAGE, SELECTED CROP REPORTING DISTRICTS, 1962, 1972, 1982

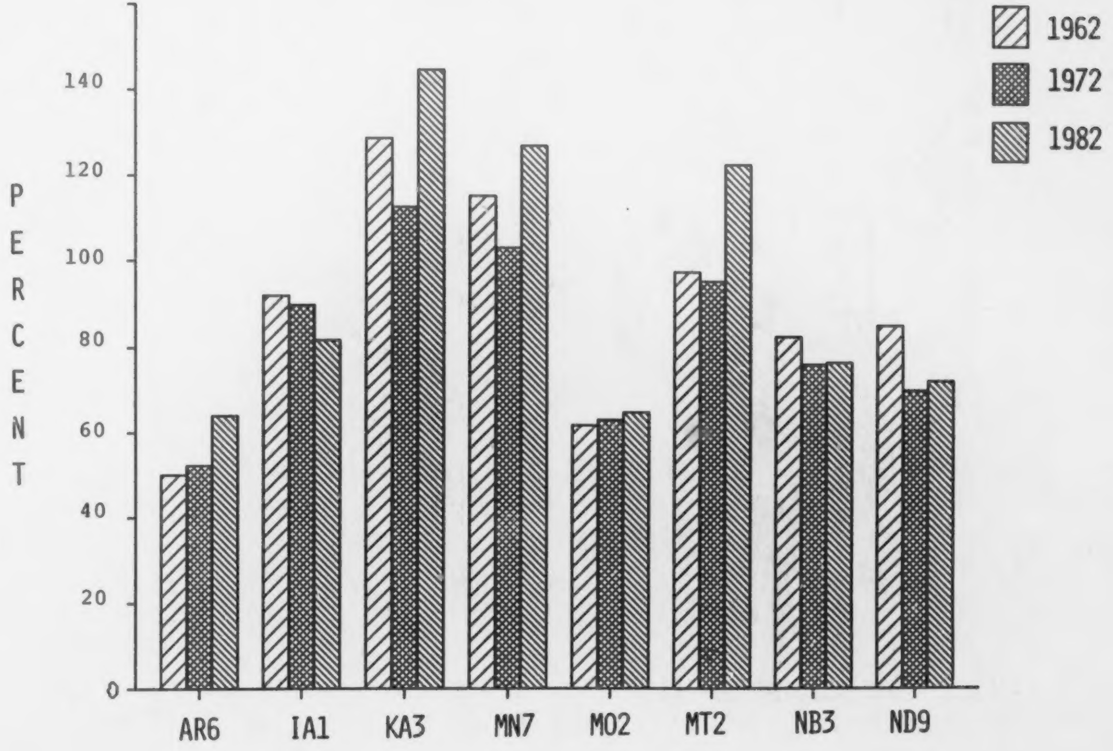


FIGURE 16: PER PUPIL EXPENDITURES ON EDUCATION, AS A PERCENT OF NATIONAL AVERAGE, SELECTED CROP REPORTING DISTRICTS, 1962, 1972, 1982

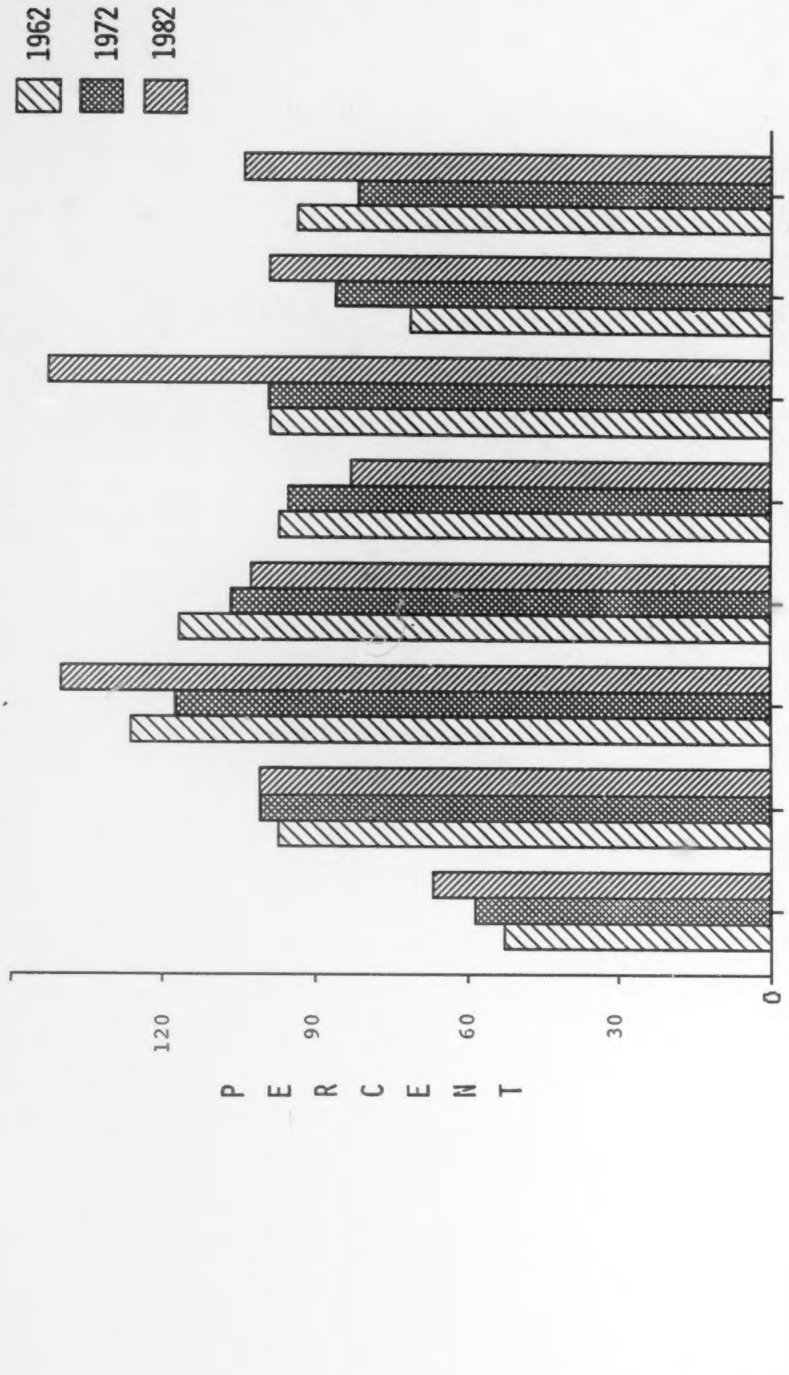


FIGURE 17: LOSS OF LOCAL GOVERNMENT REVENUE DUE TO A 10 PERCENT CUT IN PROPERTY TAX REVENUES, SELECTED CROP REPORTING DISTRICTS, 1982.

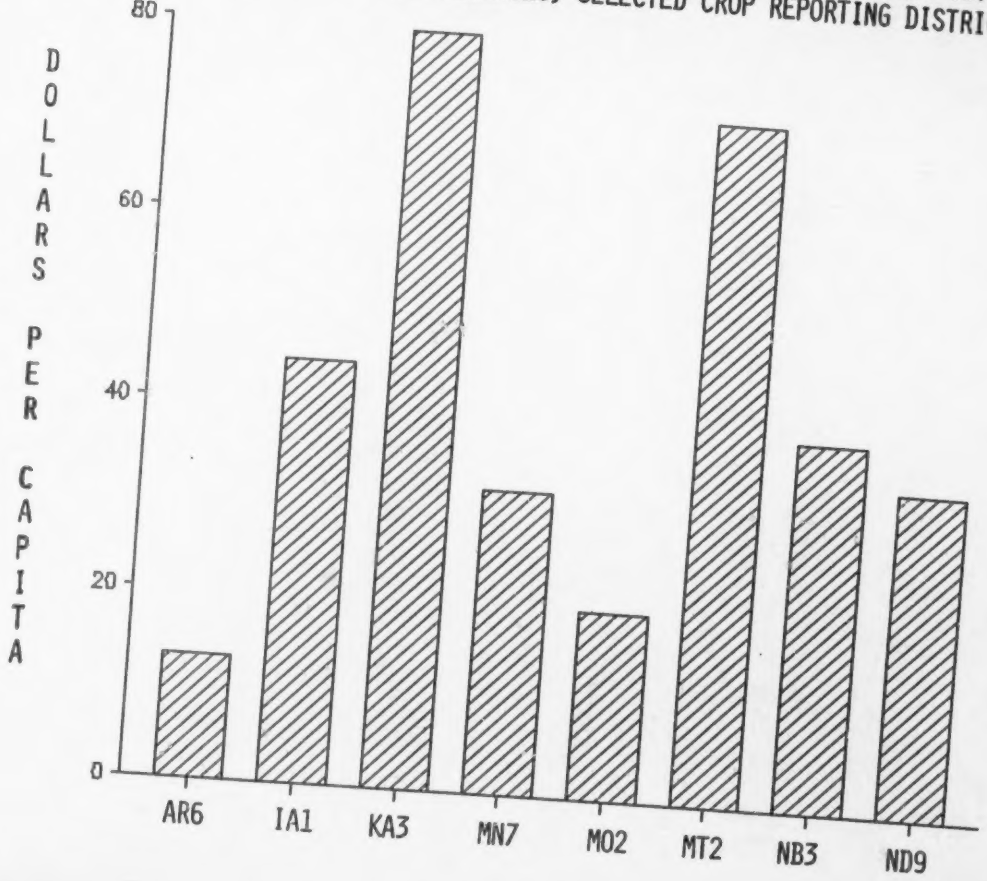


FIGURE 18: ESTIMATED LOCAL EXPENDITURE DEFICITS ATTRIBUTABLE TO LOWER PROPERTY TAXES AND CUTS IN AID, SELECTED CROP REPORTING DISTRICTS

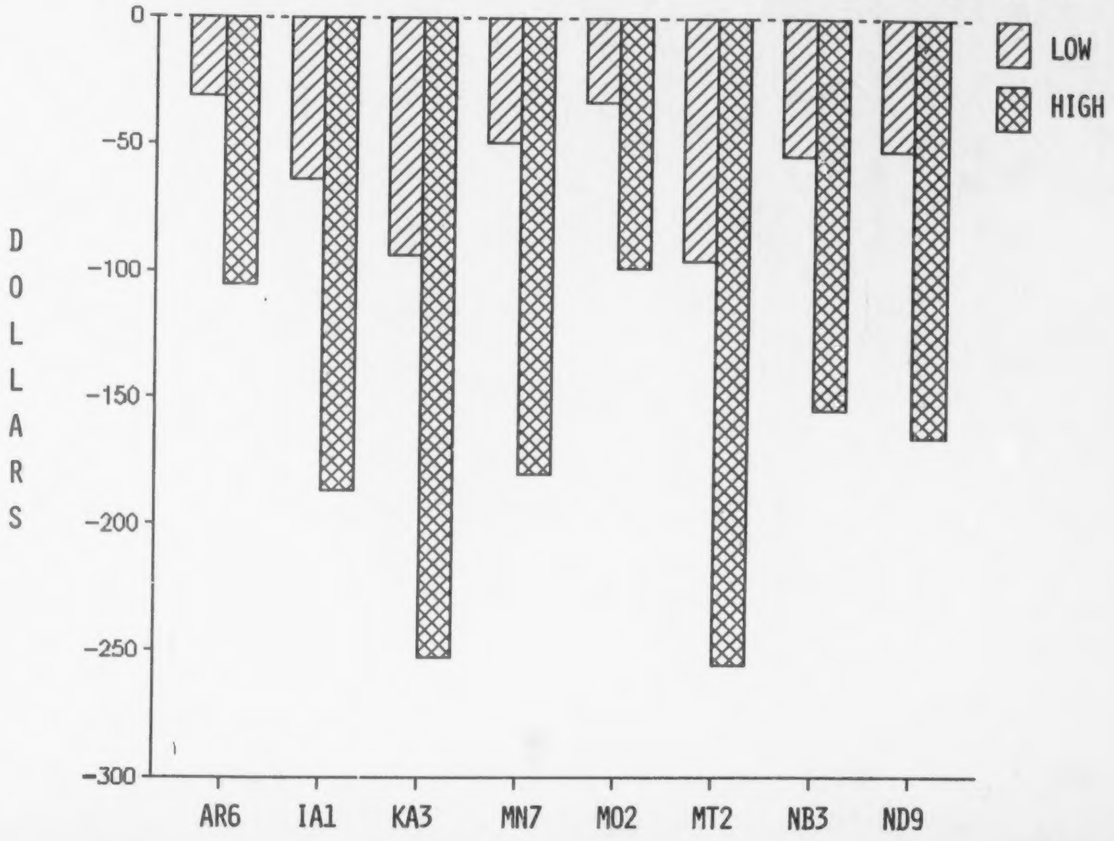


FIGURE 19: COMBINED IMPACT OF LOWER PROPERTY TAX RECEIPTS AND CUTS IN FEDERAL AND STATE AID, SELECTED CROP REPORTING DISTRICTS, 1982.

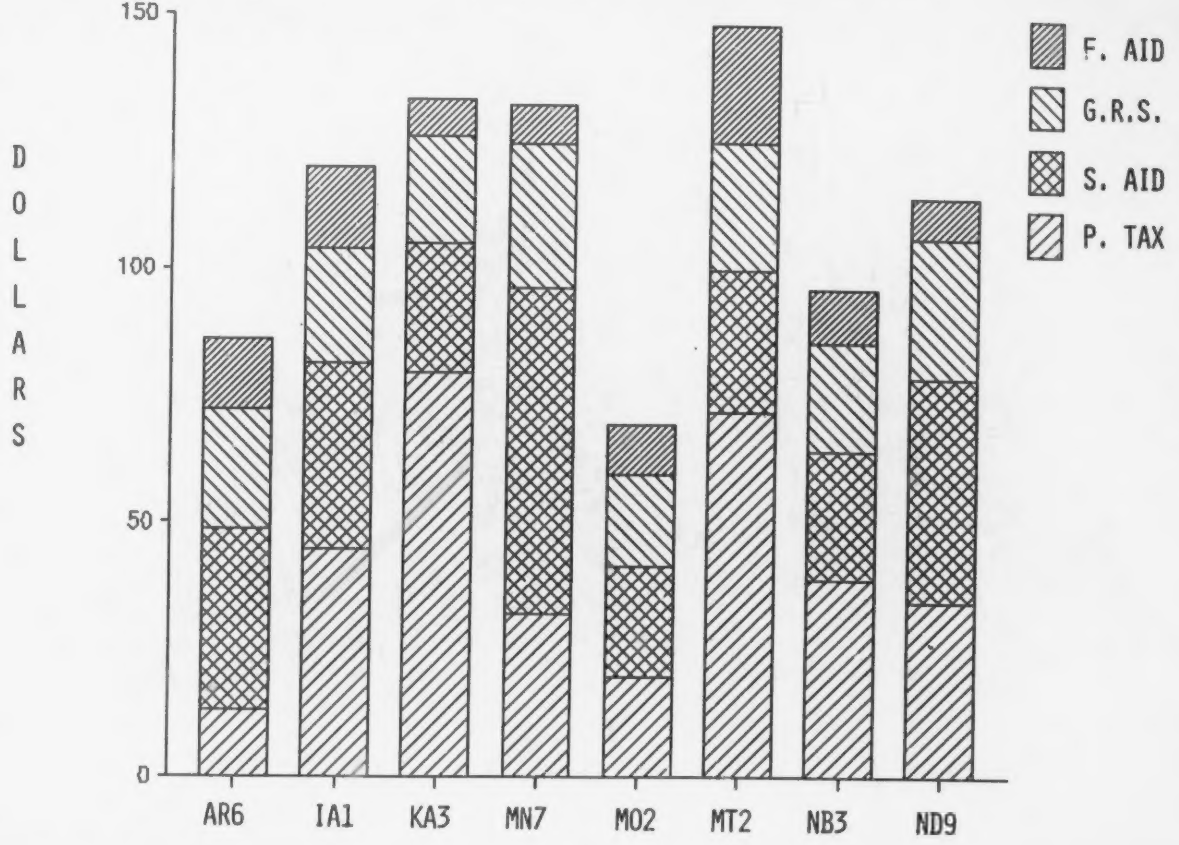
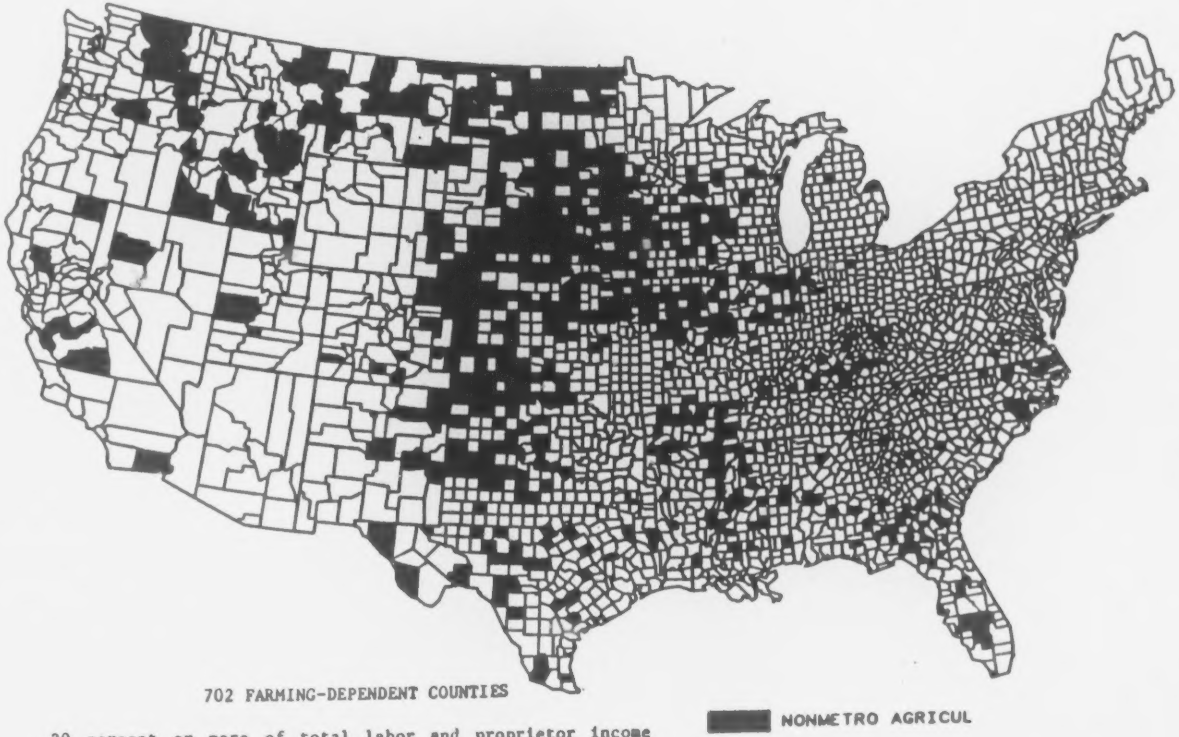


Figure 20:
NONMETRO AGRICULTURE COUNTIES

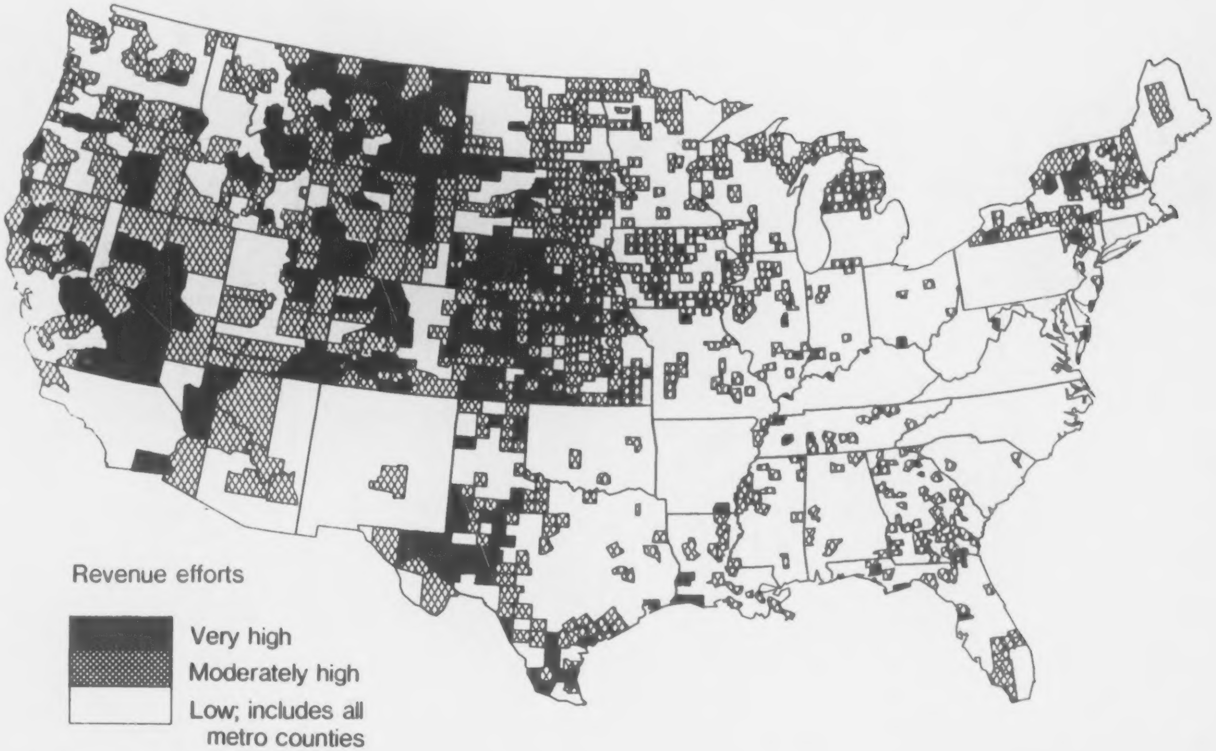


702 FARMING-DEPENDENT COUNTIES

20 percent or more of total labor and proprietor income was from production farming/ranching during 1975-79.

SOURCE: ECONOMIC RESEARCH SERVICE, USDA

Figure 21:
Nonmetro Counties with High Revenue Efforts in 1977


Revenue efforts
Very high
Moderately high
Low; includes all metro counties

SOURCE: ECONOMIC RESEARCH SERVICE, USDA

TOOLS FOR COPING WITH CHANGE—PRELIMINARY REPORT TO THE NORTHEAST-MIDWEST COALITION

INTRODUCTION

In 1986, a report entitled "Governing the Heartland: Can Rural Governments Survive the Farm Crisis?" was published by the Intergovernmental Relation Subcommittee, which I chaired. The thrust of that report was that Federal policy must recognize the inter-connection between all the elements of rural life. What began as a crisis in agriculture in the early eighties and in energy in the mid-eighties has become a crisis for the entire heartland. It is not just farmers and miners and plant workers who are threatened: it is also teachers, health professionals and other service providers. In order to deal with rural problems, attention must be paid to the entire system, not just a single element.

This preliminary report is a continuation of that effort to encourage policymakers to take a comprehensive approach to rural development problems. On the basis of a number of field hearings around Minnesota, this report discusses current economic development problems and opportunities, and presents recommendations for Federal action. In addition, this report recommends a number of Federal actions to respond to the current drought in the upper Midwest.

The Northeast-Midwest Coalition is a bipartisan alliance of 36 U.S. Senators from the Midwest, the Mid-Atlantic, and New England, who organized in 1978 to better serve the interests of their States. With the assistance of the Northeast-Midwest Institute, the Coalition seeks to develop Federal policies and legislation to address economic development, infrastruture and resource issues. In February of this year, the Coalition created a Rural Economic Development Task Force, Co-chaired by Senator Tom Harkin (D-IA) and myself.

The Senate will soon consider both a rural development bill and a drought relief bill. It is hoped that this report will help direct further study and legislative action.

I. THE CONTEXT OF RURAL ECONOMIC DEVELOPMENT

A. The Importance of Rural America

The value of the rural economy to the national economy as a whole is frequently underestimated. In 1988, America's 2441 rural counties contained 60 million people, one-fourth of the nation's population. These counties provide:

(1) more than 90 percent of the nation's minerals and energy products;

(2) nearly all of the nation's food production and most of the wheat, corn, soybeans, cotton, and tobacco currently exported to other nations of the world;

(3) many of the large-scale public and private recreational areas, and an increasing number of retirement communities;

(4) last and most important, rural America remains the wellspring of the cultural and spiritual values that have made this nation strong. The people that settled our rural areas brought with them a sense of self-reliance and a willingness to work long and hard to succeed. But these settlers also offered a spirit of neighborliness to their fellows at times of personal and financial crisis. It is this set of values that many of our nation's leaders still retain—values that allow the nation to maintain a link with the past and provide the strength that will be needed in the future.

But all is not well in rural America. Federal data shows that:

(1) unemployment is 33 percent higher in rural areas than in the nation's large cities, and all counties with an unemployment rate double the national average are in rural areas;

(2) job formation in rural areas lags. Between 1980 and 1987, the total civilian economy created approximately 13.1 million new jobs, while the rural economy experienced a net loss of jobs;

(3) rural residents are more likely to be poor. In 1986, 9.7 million, or 30 percent of the nation's poverty-stricken population, lived in rural parts of the nation;

(4) the incidence of substandard housing continues to be more than three times as high in rural areas as it is in urban. Almost 1.9 million rural households still live in housing that is hazardous to health and safety.

B. Key Issues

Expanding unemployment, increased poverty, and declining job formation and health standards have created a need to provide rural America with a series of new economic initiatives. The incidence of substandard housing marks rural America's economic slide.

At times in the past century, the financial condition of rural America fell below that of the metropolitan US. But the urbanizing world needed the grain and forage crops grown by our Great Plains States, and eventually prosperity returned.

However, a new problem has disadvantaged rural America. The international move into the information and electronics era has created a new economic elite in those States bordering the Atlantic and Pacific Oceans. As the United States economy recovered from the 1982-83 recession, imports surged and a new group of workers emerged to service and distribute these imports. As the service economy in our nation expanded geometrically, our agricultural, forest, mineral mining and basic manufacturing sectors were hard hit by imports from low wage, newly industrialized countries. And having the greatest impact of all, the worldwide "Green Revolution" created agricultural gluts in nations that had not been able to feed their populations for decades or even centuries, therefore removing the need for food from America.

With the emerging world economy of the eighties and nineties, a far higher premium has been placed on maximizing the efficiency of the American economy to bolster its competitive position. Venture capital that was once available in the rural economy has been diverted to faster pay-off, high growth investments. At the same time, Federal tax policy has tilted even more steeply toward a consumption economy, rather than a savings and investment economy, exacerbating rural America's capital problems. For these reasons, rural areas have been slow to recover from the early eighties recession, and in some ways, the general recovery has proceeded at its expense.

In spite of these recent trends, the food-producing capacity of "Heartland America" remains one of the world's strategic assets. But if the products provided by this region continue to decline, the nation could continue its current drift into "two Americas," and the distressed economies located between the Sierra and Appalachian Mountains could come to depend permanently on Federal subsidies from our coastal States. We must innovate and create new products and services provided by rural America. If we are to respond adequately, we must rally to the challenge facing our agricultural and manufacturing base.

C. The History of Rural Development

Federal programs designed to support economic development in rural areas are as old as the nation. In the 175 year period between 1789 and 1964, most rural development programs created by Congress were narrow in scope and intended to provide rural America with technologies and amenities that had become commonplace in urban areas.

The demographic changes in rural America have been staggering. In 1900, over 60% of the United States' 76 million citizens lived in "non-metropolitan" places. By the year two thousand, it is estimated that only one in four will remain there. While urbanization has its economic advantages, there are obvious signs in our culture and social structure of some of its cost.

Three of the most important 19th Century rural development initiatives include:

(1) construction of the "National Road" from Baltimore and Washington D.C. to Ohio, then to Indiana and finally to the edge of the frontier in Illinois;

(2) land grant awards totalling a billion acres to a small number of railroads, permitting them to complete the nation's transcontinental rail system;

(3) the Homestead Act of 1862, which provided land grant programs used by the States to create a system of public universities (then called agricultural and mechanical colleges) in each State. These colleges provided a post-secondary education to many young people that otherwise would have been denied it.

Major 20th Century rural development single purpose programs include:

(1) paved "farm-to-market" roads
(2) rural electrification and telephone service
(3) rural parcel post delivery
(4) sewer and water treatment facilities
(5) farm credit and secondary market programs

After 1965, the narrow single purpose programs gave way to a variety of multipurpose programs, including the Rural Development Act of 1972 and the Rural Development Policy act of 1980. These acts were adopted in an era in which the Federal government dictated the content of local programs from Washington D.C. or from regional offices in large cities, far from the community where the program or project was implemented.

The 1972 Act required that a local planning process be developed prior to the funding of any local project. Unfortunately, Congress did not provide planning funds until seven years after the legislation was signed into law, and then for only two years. The result was that many rural development projects were funded by USDA without coordination of local and national goals.

The national strategy requirement of the 1980 Policy Act was infrequently honored by the USDA Undersecretary for Small Communities and Rural Development. Hence, rural communities lacked the program focus that could have resulted from a coordinated national rural economic development policy.

It is also important to recognize the trend in overall U.S. social policies during this period, of which rural development is just a part. From the period of the late sixties until the start of the deficit problems in 1978 to the present, there has been a basic change in the role of the Federal Government. During the prior period, State and local areas, in effect, traded control for dollars: "we, the Federal Government, will give you funds if you, the local constituency, will solve your problems our way." Beginning in 1981, we have embarked on a course of *de facto* "devolution"; the Federal Government laying off responsibilities to small units of governments. Unfortunately the devolution has fallen far short of a "new federalism" for two reasons: 1. the Federal Government has thus far not been able to subdue its desire to tell the local units of government what to do, and Washington continues to issue costly mandates; and 2. the Federal Government has not provided the "tax room," i.e. returning the States' traditional revenue raising opportunities. The result has been a lopsided intergovernmental relationship, where Washington is doing all the taking and rural units of government are doing the giving.

D. Successful and Failed Rural Economic Development Programs

In general, the narrow single-purpose programs discussed above have been successful, while the more recent multi-purpose programs have not met the expectations of their authors.

Characteristics of successful rural development programs include:

(1) a narrow, easily understood mission. For example, one important rural economic development program had as its goal the mission of providing electric power to America's farmers and rural residents;

(2) the use of a proven technology to provide the service (i.e. the electric light, telephone, and paved roads) were a proven fact in towns and cities before they were extended to rural areas and could be provided to rural residents with no new technological innovations;

(3) a system construction that could be spread over a number of fiscal years, resulting in a close relationship between the amount of the system to be built in any year and the sum of money made available for construction;

(4) a system desired by the constituency it is designed to serve. For example, rural Americans knew about electric power a long time before it was extended to rural areas and most rural residents desired this service;

(5) little long-range planning was required by the rural residents who would benefit from the new service.

Less successful programs include those that:

(1) provide insufficient funds to reach the goals of the program;

(2) contain eligibility criteria that prove difficult to understand and that cause local jurisdictions be episodically eligible;

(3) require substantial amounts of inter-agency coordination at the Federal and State levels of government;

(4) the Federal department designated as the lead agency has only a marginal "stake" in the program;

(5) utilize Federal personnel that already have other full-time program responsibilities; and

(6) require a substantial amount of complex, long-range planning by the people the program is designed to serve and little or no effort is made to train the local elected officials and private citizens who are responsible for the planning.

E. The Future Role of Rural Communities in the National Economy

If the rural economy is to play an important role in the continued development of the nation over the next 10 to 15 years, it must be restructured and several urgent realities must be addressed.

Some of the more important of these realities include:

(1) the realization that manipulation of natural resources no longer *guarantees* economic success;

(2) control over local destiny in many rural communities is diminished;

(3) rural areas will continue to depend on volunteer leadership;

(4) service demands on local governments are expanding as revenues diminish;

(5) there are strong economic forces which tend to draw human and financial resources out of rural America;

Coming to grips with these and other economic changes will present a number of serious challenges to rural America including:

(1) the need to improve the competitiveness of rural businesses by using new technologies to create new products from resources common to the rural sections of the nation;

(2) the problem of diversifying the rural economy by taking advantage of new development opportunities not directly related to value-added manipulation of raw materials;

(3) the challenge of maintaining and improving the rural quality of life in education, health care, community services, and environment.

II. DIRECTIONS FOR NATIONAL POLICY: THE MINNESOTA EXPERIENCE

During three State-wide trips around Minnesota in March, April, and May of this year, I had the opportunity to conduct informal hearings with a wide variety of groups and individuals in over thirty communities. Over six hundred Minnesotans participated in those meetings, with over one hundred giving testimony or submitting Statements in writing. Those who participated included local elected officials such as mayors, city council members, county commissioners, regional development commission members, as well as staff. In addition, bankers, local business owners, representatives of private economic development initiatives, and farmers took time to share their concerns. These meetings served to complement and supplement the knowledge I have gained from literally hundreds of meetings over the last ten years across Greater Minnesota. While only a few of those meetings could be transcribed, a wealth of information was presented. In the next several pages, I want to try to summarize the rural development problems which were discussed, the opportunities which also exist, and present a number of policy recommendations for Federal action.

The Minnesota experience, I believe, is similar to conditions elsewhere, both as to problems and opportunities. The lessons and recommendations which come out of our experience have general applicability to other regions of the country, and form a solid base for national action.

A. Nature of the Rural Development Problem

Based on my experiences in Minnesota over the last several years, the nature of rural economic development problem appears to break down into three areas of concern:

1. Rural Competitive Disadvantages.—It is a basic economic fact of life that goods and services, and the jobs which produce them, are allocated by the marketplace to areas of concentration of population. This "law of large numbers," as I call it, means that the ability to spread costs over a large market base, economies of scale, and potential for growth will mean that without some changes in policies, economic activity will continue to gravitate toward areas like the Twin Cities. The law of large numbers also creates a self-reinforcing trend: as the rural economic base shrinks and the urban/suburban economy grows, the trend toward urbanization accelerates.

A secondary effect is the competition which develops among businesses and towns within the rural economy. Not only must businesses and towns compete with the Twin Cities for resources, population and skilled labor, but they must also compete against each other.

At the macro economic level, rural areas have suffered from increased competition for customers in the international marketplace. Because of massive debt problems faced by many third world nations, we have inadvertently created powerful incentive for those planned economies to shift resources into agricultural production in order to obtain hard currency. That has turned many former customers into competitors. Producers of agricultural commodities lose both ways.

In addition, the rural economy has suffered at least three "body blows"; economic catastrophies whose ramifications are still rippling through the rural economy. The grain embargo of 1979-81 severely damaged the reputation of the United States as a reliable seller of grain, and at the same time sent a strong signal to other nations, such as Argentina and the EEC, to increase production to fill the gap in the market.

The farm crisis of the 1980's, from which we have only just begun to emerge, with low commodity prices, credit shortages and falling land values, devaStated the rural economy by undermining the rural tax base, financial institutions and the health care system. The injection of Federal funds through the 1985 farm bill and the Farm Credit Act of 1987, together with the positive effects of low interest rates and energy costs and a more realistic dollar had begun a rural recovery of sorts.

The third and most current problem is the continuing drought of 1988. The absence of proper rain fall, catastrophic small grain crop losses, and the absence of affordable feed for livestock and dairy producers threatens to wipe out all the gains of the last several years. The victims of the drought are not just farmers; small towns, which depend on agricultural business, purchases and tax revenues, are hurting now and will be hurting in the months and years to come.

2. Governance Problems.—In my 1986 report as Chairman of the Intergovernmental Relations Subcommittee entitled "Governing the Heartland: Can Rural Governments Survive the Farm Crisis", we established the economic links between the farm economy and the broader rural economy, specifically as it relates to the ability of rural governments to provide necessary services to their constituencies. Given the nature of the fiscal structure of those governments, that report indicated that the declining land values and agricultural sales would nearly bankrupt most rural governments and accelerate a downward economic spiral as declining public services and quality of life would lead to a population decline and further erosion of the tax base.

The experience of the last several years has confirmed the conclusions of the report. Fortunately, the improvement of the farm economy has mitigated some of the effects on rural government, but drought problems once again threaten to restart the downward spiral described by the "Heartland" report.

Maintaining strong, independent local units of government is essential to revitalize rural communities; economic events of the last decade have tended to undermine rather than reinforce local government.

3. Quality of Life Problems.—The key to maintaining the rural population base is a desirable quality of life for rural citizens and families. Economic competitiveness and governance difficulties provide a dual threat to rural quality of life.

Job opportunities for both heads of households and other family members are necessary for an adequate standard of living. Off-farm income has been shown to be a key element in the livelihood of farm families, because it compensates for seasonal cash flow problems and short term price fluctuations. Providing jobs for young people is a major attraction to keeping their skills and purchasing power in town. Also, jobs off of the farm sometimes offer the benefit of health insurance. Without this benefit, many farm families would not carry health insurance, since the cost is prohibitive. While the job may not mean a great deal of take home pay, the benefit of health insurance for the family can outweigh the low pay and time away from the farm.

Rural government services, education, infrastructure, health care, and fire and police protection are the other major quality of life factors. Education, which is primarily a State and local responsibility, is a critical factor because it determines the skills level of future employees, and is an important factor for young families.

A major problem on the horizon for rural communities is the threat posed to rural water supplies by groundwater contamination. 90% of rural Minnesotans drink their water "raw" from underground sources instead of treated water systems. Recent tests in various places around the upper midwest have shown an alarming increase in the number of wells contaminated by pesticides and fertilizers. Rural communities can ill-afford the costly process of cleaning up contaminated groundwater or providing alternative supplies. Vaughn Bien, the Mayor of Goodhue, Minnesota, (population 657) discussed with me in February the plight their community faces as they try to find a source of drinking water as their municipal well was tainted by nitrates. This contamination made Goodhue's water supply unsafe for infants under six months of age to consume. Goodhue has a total annual budget of about $173,000, yet the community is spending about $300,000 to extend its well into deeper and cleaner groundwater and to dig a second well. As this example shows, it is a costly process with a very costly drain on the local economy.

B. Rural Economic Development Opportunities

In the discussion of the problems of rural communities, it is very important not to obscure the numerous important economic development opportunities which exist in rural communities, which point to a very different and promising future, if the forces of change can be properly managed and rural citizens are given the proper tools to cope with change.

There are several advantages which rural areas enjoy in the area of economic competitiveness over suburban/urban areas:

1. *Innovative uses for agricultural products.*—Because of the burgeoning bio-technology industry and concerns over new methods to find reliable, environmentally safe methods of providing products from energy to packaging, there is new interest

in using agricultural products to serve a number of domestic and international markets.

Ethanol production, which utilizes corn to produce fuel and gasoline additives, offers a secure and clean source of energy for the United States. As lead is being removed from America's gasoline supplies, ethanol becomes more attractive as a clean burning, high octane additive.

Minnesota has a corn processing plant located in Marshall (population 11,000) Minnesota Corn Processors, the farmer-owned cooperative which started in 1980, has 2,100 members who have the objective of generating higher returns for the corn production of its members by processing corn through a wet milling plant into starches, syrups, and feed products. Earlier this year, MCP decided to expand, and are in the midst of completing their start-up phase for ethanol production.

Recent research has demonstrated the feasibility of making biodegradable packaging material from corn. The distinct advantage of biodegradability addresses the critical issue of solid waste disposal far better than plastic alternatives. In fact, the Minnesota Corn Growers Association, which has been promoting and developing markets for Minnesota corn, now has developed this type of bag.

Continuing research also promises the production of soybean oil as an additive in printing ink, replacing petroleum-based ink. Soy ink is competitively priced at a consistently high quality. It too is biodegradable and environmentally safe, reducing disposal problems. In addition, soy ink has less rub-off and gets better "mileage" on the press. In Minnesota, there are several publications using soy ink, including the Rochester-based *Agri News, Western Printers* from Montevideo, *The Farmer/The Dakota Farmer*, the *St. Paul Pioneer Press and Dispatch*, and the *Waseca Area Shopper*.

Another development occuring with the assistance of the American Soybean Association is the use of Soybean Crop Oil in pesticide application. Soybean Crop Oil may be used as a wetting agent to reduce the surface tension of the pesticide spray droplet, reducing the tendency of the spray droplet to bead up on the leaf and increasing the leaf area covered by each droplet. Soybean Crop Oil is currently being produced by Cenex/Land 0' Lakes, two regional farm cooperatives headquartered in Minnesota.

2. *Close to the farm, value-added processing.*—In recent years, positive results have been enjoyed by a number of communities that process agricultural products close to home, rather than simply shipping raw material for remote processing. This provides a more economical use of these commodities through decreased transportation of bulk materials and shipment in finished form. The economic benefits to communities are significant as a source of off-farm income.

I witnessed an outstanding example of this in Perham, Minnesota (population 2,000), which boasts 21 businesses. Using locally grown commodities such as 35 million pounds of potatoes and 1.25 million pounds of popcorn, Barrel 0' Fun Potato Chips manufactures potato chips and other snack foods nationally. The Perham Egg Plant processes 18 million dozen eggs—that's 216 million eggs per year! Tuffy's Pet Food uses 6 million pounds of corn gluten meal and 4 million pounds of flour. 3,000 semi-loads of materials arrive a year, shipping out 25 semi's a day. The dairy industry in the area is not to be forgotten: when the remodeling is completed this summer, the world's largest cheese plant, owned by Land 0' Lakes, will be located in this community that is some 150 miles from the Minneapolis/St. Paul metropolitan area. 40 semi's pass through the cheese and dry milk processing plant. The success of Perham didn't just happen by accident; there were entrepreneurs, like Kenny Nelson and his late father, who developed their ideas and built on the concept of using the local products and processing them before shipping them out of the community. Through their work, the Nelson's created over 800 jobs in the community. Perham uses a different approach than most to attract business—they don't make promises to give land away or give tax benefits—they expect industry and businesses that move to their community to pay their own way. The community leaders believe that success breeds success.

3. *Dispersed information processing.*—An important growth area in our economy has been created by telecommmunications technologies, which virtually eliminate traditional notions of the work place. Through computer networks, it is unnecessary for workers to be centralized in one location; workers can perform information processing operations at remote sites, and information, rather than people, are moved. With labor shortages in urban areas and labor surpluses in rural areas, there are tremendous opportunities for diversification of the rural economy through information processing.

We witnessed what may be the vanguard of this kind of activity in Internation Falls, Minnesota, with several dozen workers employed to process insurance forms for a New York City firm. Labor shortages in large cities will persist and grow over the next two decades; communication links between that shortage and the rural labor surplus can solve two economic problems at the same time.

4. *Rural entrepreneurship.*—The traditional nature of the rural economy has been one in which the industries of agriculture, forestry, and mining are primary. While these industries will continue to be the staple of the rural economy, we are witnessing in Minnesota the emergence of rural entrepreneurs; business people with innovative ideas for products and services which take advantage of the strength of the rural economy, and successfully target markets in urban areas.

One example that we have observed in Minnesota has been the development of industries which complement the agricultural economy. For example outside of Luverne Minnesota a thriving fur industry has grown up. Because of the seasonal dynamics of mink farming labor is needed in the late fall and winter months, when agricultural workers have greater opportunities to work off of the farm. Feeding the animals also consumes locally produced grain and organic solid wastes. Mink farms have made a small but valuable contribution to the diversification and stability of an area which is highly vulnerable to cyclical changes in the farm economy.

We observed another example of rural entrepreneurship in Young America, Minnesota (population 1,237) The Young America Corporation handles manufacturers' rebates from around the country. In 1972 and 1973, the Norwood/Young America Development Corporation helped this business get started through an SBA 501 loan. Banks also participated—bonds were sold, creating bond holders. At the start they employed 19 people, and now they employ some 1,200 people. Part of the reason for their success is Jay Ecklund, the president of the corporation since 1978.

Yet another example is the Minnesota Marketplace program, which is coordinated through the Region 5 Development Commission based in the north central city of Staples, Minnesota. This program is designed to create and retain jobs through import substitution. Rebecca Sellnow, the business developer for the program, meets with businesses and helps them identify goods and services that are currently purchased outside of the State of Minnesota. Minnesota Marketplace searches for existing suppliers in Minnesota that could produce and/or supply the goods and services needed. The name of the purchasing business is kept confidential. The goal is to bring savings to the purchaser and additional business to the supplier. Seven months after the program began on June 1, 1987, 5 jobs were created, 20 were retained, $212,000 in contracts were awarded to local businesses, $20,000 was spent in new capital expenditures, and $30,000 in savings to the purchasers was realized. This is a total economic development program.

These are but a few of the many examples of the ingenuity of rural entrepreneurs who are tapping the competitive advantages of the rural economy to provide jobs and diversify the economy.

5. *Local leadership.*—There is great value, in an economic sense, in people who are willing to make an investment of themselves and their resources in the viability of a town. Loyalty to a place, rather than pure profit motive decision-making, is a powerful force. In many of my meetings across Minnesota, I witnessed outstanding local leadership which (1) assessed the needs of their community; (2) sized up the competition for resources they needed and products they could produce; and (3) implemented a plan to point their community in the right direction and get citizens to pitch in together to get the job done.

Madelia, Minnesota was an excellent example. Drawing together the various elements of the community—business, government, civil organizations, churches and farmers—the community leaders of Madelia developed what amounted to a survival plan for the town. Though the unified efforts of folks pulling together, they were able to pull Madelia through tough times. Now there are new businesses on Main Street and the town has a very successful revolving loan fund for business expansion and new start-ups. But the key was the leadership that could pull the town together—the leadership of Mayor Dale Williams, the city council, business owners, and concerned citizens who were willing to be open and talk about the impact of the farm crisis on their businesses, families, and the community. Without their dedication and the dedication of countless other elected officials, small communities would be left in the dark to work on economic development.

Minnesota has also benefited greatly from regional development commissions, of which there are nine in Greater Minnesota. These State-chartered organizations, made up local elected officials, supplement local community leadership in three ways:

(1) they provide essential communities with information and technical and legal help regarding State and Federal grant and loan programs to provide capital to businesses;

(2) they provide access to other kinds of marketing and technical studies about new products and uses;

(3) they provide a planning component within regions, so that communities develop complementary rather than competitive economic plans.

A unique concept was explained to me by Larry Anderson of Frost (population 250) in the southern Minnesotan county of Faribault. Faribault County is a rural county with no major population center. The total county population is 19,000, with its small cities ranging in size from a couple hundred to about 4,000 people. Instead of competing among themselves, the communities united to create the Faribault County Economic Development Commission. Their goal is to "sell" the entire area. With the support of the County Board of Commissioners, they accepted the responsibility for funding and staffing their own efforts. With a beginning annual appropriation of $100,000 to hire professional staff, they began a marketing campaign, brought community leaders and organizations together, and (most importantly) brought new jobs to Faribault County. The results since June of 1986 show 61 new full-time equivalent jobs and a payroll of $686,000. They have also established a revolving loan fund which has assisted 11 county firms with loans that total $211,000. The total investment for the projects of these 11 companies is more than $2,000,000. This amounts to an investment per job of $3,653 by the county development agency. Each dollar invested by the county has brought a return of more than *nine dollars*. This was accomplished in 22 months!

There are four other forms of rural leadership which help to maintain continuity and direction in rural Minnesota.

First, Rural Electric Cooperatives: For most of this century, cooperatives have been the sum and substance of development effort. Addressing the competitive disadvantages of rural citizens as both buyers and seller, and meeting their urgent needs for utilties, which the marketplace would not or could not produce, coops have done a tremendous service to rural residents. The Cooperative will continue to provide a vital source of leadership and market-based expertise for solutions to today's rural problems.

Second, religious and fraternal organizations have been the backbone of the spiritual integrity of rural communities. Meeting the tradition needs of families and the needy in rural communities, as well as non-traditional services such as insurance sales, these organizations teach and practice the values for which rural areas are renown. In my own State of Minnesota, the Rural Life Councils of various dioceses of the Roman Catholic Church and Lutheran Social Services ministries have provided important sustaining strength during the difficult times of the last decade, especially when the public agencies could not meet many social needs, and can be depended upon to provide leadership in the future.

Third, philanthropic organizations also make valuable contributions to rural communities. The McKnight Foundation, the largest philanthropic organization in Minnesota, announced in March of 1986 their plan to give away $15 million over two years to *outState* economic development and human service programs. OutState Minnesota contains half of the population, but receives only 11 percent of Minnesota's foundation money. As a result, six regional "initiative funds" were organized and between 2.1 and 2.9 million dollars were given to seek new ways 21 stimulate economic development and to address human needs. McKnight's goal is decentralized grant-making that uses the people closest to the problems to make decisions. Each region has its own board of members from a diverse background; from education and social service to civic activity, business and government.

Finally, the new actor on the rural economic development horizon is the Greater Minnesota Corporation, which will manage State development programs in rural areas, as well as provide valuable technical and government liaison services to rural communities. Organizations of this type can play a very important role in mediating the relationship between local governments, State agencies and Federal departments. This can be an extremely beneficial factor in getting help where it is most needed and can do the most good.

6. *Rural quality of life.*—There are still substantial attractions to rural living which will continue to meet the needs of current residents and provide attractions for those who live in growing urban and suburban environments. As the basic infrastructure systems of the urban areas in transportation, disposal of waste and pollutants, and social services reach capacity in the next decade, there will be an increasing need for recreational opportunities in rural areas. Leisure time is projected to continue its increase, with a greater demand for recreational activities. With the potential for the dispersion of information technologies, we may even see a reverse migration of some level.

One situation I encountered was the case of the Seafest Corporation, an employer of 140 people in Motley, Minnesota. When Seafest's parent company, International Multifoods of Minneapolis, sought a manager for its subsidiary, they wanted an expert in the crabmeat market. They found that person in Motley's Loren Morey. When Morey refused to leave his home town in the lake country of central Minnesota, International Multifoods decided to move its subsidiary to him. That turned out to be a wise decision for the company, as well as a very desirable outcome for both Morey and his neighbors in Motley.

7. *Rural Education.*—Education is extremely important to Minnesotans, especially to those from small towns around the State. The pride of a community in many cases is its school band, the debating team, and its athletic programs. In addition to the contribution of these extracurricular activities, most citizens want to make sure that their children receive quality education from kindergarten through 12th grade and beyond. The school becomes the hub of activity for the community, and the residents know that schools are where the future of their community and country is determined. This is why schools are pairing and sharing programs to enable their students to have the best education possible. This is also why telecommunications systems are playing a role in linking various school systems together. A computer system in west central Minnesota links the paired school system of Elbow Lake, Wendell, and Barrett with the school systems of Battle Lake, Underwood, and Ashby.

Equally as important as the early years of education are the community colleges, area vocational technical institutes, the State college system, and the University system, in meeting the needs of State residents. Education is extremely important in determining the future of individuals, and may assist them in making a career change to meet their needs. For example, the Granite Falls Area Vocational Technical Institute has retrained 18,000 people for employment. Much of the need for re-training resulted from the farm crisis, which caused farmers or their families to seek outside sources of employment to contribute to the family income. With a quality education system so close to them, people in the Granite Falls area were able to gain additional skills without having to spend a great deal of money.

In addition to re-training persons suffering from the farm crisis, schools also contribute to the rural economy through technological innovations. For instance, Marshall's Southwest University offers a "Science and Technology Center" that has been very innovative with incubators.

8. *Rural Resilience.*—And finally, all of these factors, plus an intangible but very real sense of determination which I have experienced in the people of Minnesota's rural communities, is a unique rural resilience. These people have already survived many an economic downturn and natural disaster. Their fortitude is described by many as a "pioneer spirit" inherited from their predecessors on the prairie. I believe that the character of rural Minnesota goes beyond the "pioneer spirit" and includes a strong work ethic to get things done and get them done correctly. It is also built on a sense of caring for the community and family. In many of the small towns and cities around the State, people know each other well, and they all work together to solve the problems of the members of the community. Their ties to the family go beyond their neighbor down the road or across the street, or their third cousin by marriage. As the saying goes, you can take the girl or the boy out of the country, but you can't take the country out of the girl or boy. A person from the country never leaves it—when they return home, someone will always wave a hand to welcome them. Many rural residents also have a spiritual belief that working together can accomplish the impossible. Any economic analysis which fails to account for this determination to stay and make a go of it regardless of the circumstances is destined not only to sell these people short, but to fail in its overly pessimistic predictions.

C. National Purposes in Rural Development

There are indeed signs for optimism in the rural communities of Minnesota, in spite of the difficulties of the last decade. The challenge to government at all levels is to find ways to

(1) address those problems which still create competitive disadvantages, quality of life concerns and the crisis in rural governance;

(2) encourage diversification, innovation, entrepreneurship, local leadership and quality of life advantages, and

(3) in an era of severely constrained resources in Washington, and in light of the failure of past efforts to stimulate rural development, to create tools by which local leadership can cope with changing economic conditions.

Government cannot, and should not, be a managing partner in the revitalization of rural communities. But it should do its best not to exacerbate problems, and should cooperate where it can in the efforts of rural communities to solve their own problems and take advantage of their own opportunities. To carry that out, we need to define and understand the national purposes of rural development and make policy recommendations to carry them out.

America's stake in these communities and its rural citizenry is not based on nostalgia or Norman Rockwell appreciation for the pastoral existence of rural life. It rests instead on an appreciation for the contribution small communities, small businesses, and families make to the economic and social fabric of our nation. We can ill-afford, in an era of increased international competitiveness, to allow the value of our rural resources to decline. Centralization of the farm economy and the accumulation of large areas of land by corporations is neither good economic nor social policy. Central cities are not equipped to receive an influx of population from rural areas which can no longer sustain its population base. Government is not in a position to step in and provide all of the social services these towns provide to their citizens because they are a "community."

All Americans have a stake in rural America, and our national priorities and actions should reflect that fact.

D. Recommendations for National Policy

The following six principles are presented as logical and effective components of a national rural development policy. They do not exhaust the legitimate role of the Federal government, but they appear to be areas in which the national government can cooperate, make a long term commitment that can be kept, and efficiently utilize the scarce rural development funds that are likely to be available in times of increasing fiscal constraints at the Federal level. Where appropriate, specific solutions are proposed.

Recomendation 1: Setting National Economic Policies That Contribute to the Vitality of Rural America

The first job of the national government must be to create the economic climate conducive to growth in the rural economy. Rural America has suffered greatly under economic policies which created or permitted: high inflation and interest rates; an overvalued dollar; unfair trade practices; and high energy prices.

There have been some beneficial effects over the last several years of low inflation, a more realistic dollar, and low energy prices. These gains should be preserved.

But the Federal Government must take a more aggressive stance on resolving inequities in international trade, which favor Canadian and EEC agricultural products over U.S. products. In addition, action must be taken to resolve third world debt problems which encourage Latin American nations to compete against our exports instead of consuming them.

Recommendation 2: Encourage Local Leadership Problem-Solving

It is clear that we cannot create a system that sends Federal dollars in search of a local problem to solve. The initiative must be from local communities, who not only understand their problems better than distant bureaucrats, but also have a vital stake in their solution.

Federal rural development programs must encourage to the greatest degree possible reliance upon, or formation of if they do not exist, sub-State regional development authorities. These authorities should have three purposes: planning, technical assistance and liaison with the State and Federal Governments. State rural development corporations, which manage State programs and provide capital and information, should also be encouraged.

specifically, these local and State development authorities should be encouraged by involving them in the process of application for and distribution of Federal monies under the various programs of the EDA, SBA, FmHA, and other USDA programs.

Recommendation 3: Revitalize the Intergovernmental Partnership

The nineteen eighties have seen the Federal Government "devolving" a number of responsibilities to lower levels of government. At the same time the Federal Government has (1) not shared the resources needed to meet those responsibilities, (2) nor has it hesitated to load costly mandates on local government, which locals are then forced to comply with out of their own pockets. Rural communities cannot shoulder the burdens of both their own constituencies and Washington's.

The General Revenue Sharing program provided an essential relief to rural governments which ameliorated fiscal disparities between wealthy and struggling communities. The Congress, in eliminating GRS because of its inefficiency, threw the good out with the bad. First, we need to establish a form of targeted fiscal assistance. Second, we need to prevent the Federal government from passing on mandates without the resources to pay for their execution.

Recommendation 4: Make Investments in Rural Quality of Life

Improving quality of life is a key element in maintaining the population base in rural areas. The Federal Government currently makes a range of investments in these areas, which are vital to rural revitalization. They must be properly targeted and funded to help provide rural citizens with the services they need.

Education: School districts and post-secondary institutions play a vital role in training and retraining the rural work force. Information technologies can give even remote schools accesses to resources available previously only to students in urban technical schools. Department of Education grant programs like the Star Schools program help local areas obtain these information technologies, which opens the door to a wealth of educational opportunities.

Health: The availability of high quality health care is a necessity of rural life. In fact, access to health care is considered one of the most essential elements of any community. This is particularly important in rural communities because of travel distances and the critical factor of time in emergencies, accidents and deliveries. In addition, farm and highway accidents are very serious problems in rural areas. As the health system throughout the country undergoes a revolution in financing, organization and medical practice patterns, the Federal Government has a special obligation to provide and protect rural health services. Rut many changes have hit rural hospitals, rural doctors and nurses and allied health personnel, and the elderly and disabled in a particularly unfair way.

For the past three years, I have been involved with efforts in Senate and Congress to correct the severe imbalance in payments from the Federal Medicare system to rural hospitals and doctors, and to parts of the country (like Minnesota) which have had historically low health care costs. For example, Medicare payments to rural hospitals were increased 3% in the last budget bill, in contrast to 1% for urban areas and 1.5% for cities over a million people. Another front in this effort has been help for rural HMO problems and the rural nursing shortage. Soon these efforts will have a beneficial effect on delivery of health care in rural areas. Passage and funding of the Durenberger Rural Health Transition Grants program will give small community hospitals assistance to modify their service mix to better meet the needs of their communities. Dramatic increases in funding for nursing education and services will also help deal with the nursing crisis.

A Federal solution to the long term health care problem is a very important issue is rural communities, which tend to have a high population of senior citizens. The recently enacted Catastrophic Protection Act will add protections against the impoverishment of wives or husbands if the spouse needs nursing home care. The bill also offers "respite" care to give a break to family caregivers, as well as expanded benefits in home health care, skilled nursing facilities, and hospice. Soon, there will also be an important new prescription drug benefit which will be especially helpful to the sick elderly with chronic conditions and costly, long term maintenance requirements.

Environment: Growing evidence of contamination of groundwater supplies on which virtually all rural citizens depend is a major potential problem for rural communities. Federal legislation to study and direct Federal protection of groundwater should be a priority. Four bills which I have introduced (S. 1105, S. 1419, S. 2091, S. 2092) are designed to prepare the Federal and State governments to assume a leadership role in protecting and providing restoration of this resource. These bills, which also provide a resource transfer from urban areas to rural water supply systems, need to be enacted before further costly damage is done.

Recommendation 5: Conduct Rural Impact Analysis of Policies

Whether in the formal sense of a Rural Impact Statement, or as an area of heightened sensitivity in policy-making, the rural impact of various government policy and budgetary decisions must become a more important factor in Federal decision-making. This is particularly true in the areas of the deregulation of telecommunications services, financial institutions, and transportation. Federal tax and trade policies must reflect an understanding and a sensitivity to rural problems. And the Federal Government, as the largest purchaser of goods and service in country, should use its procurement policies to make a larger contribution to the rural economy.

Recommendation 6: Meeting the Need for Rural Capital

Capital for business expansion and opening new businesses is in short supply in rural communities. Outstanding results have been accomplished around the country through revolving loan programs assisted by the Federal Government. Efforts by the Economic Development Administration to bring together private funds and public funds at various levels have been very successful and should be aggressively funded. The goal of capital assistance programs should be the use of Federal seed money to create loan funds, which eventually are self-financing, rather than creating dependence on continuing Federal loans.

III. ADDRESSING THE DROUGHT OF 1988

A. The Nature of the Needed Federal Response

The most urgent need of the people and communities of the Upper Midwest in 1988 is assistance in meeting the challenge created by the drought conditions which began late last year and have become steadily more severe during the growing season.

The entire State of Minnesota is now rated very short of moisture. Small grain crops have been devaStated, as have hay and forage, and without significant moisture, row crops of corn, soybeans, and sugar beets will also be severely affected.

But it would be a fundamental error to view the drought of 1988 only as a farm problem. Helping farmers will not solve all the problems of the drought. This is a larger rural development problem. The Federal challenge is to respond not only to farmers in need, but to rural businesses, governments, and social services, who are and will be experiencing a drought of sales and revenue while they have a flood of demand for services.

B. The Budgetary Impact of the Drought

The Federal budget for FY89 and FY90 was based on certain assumptions which have been changed radically by the drought of 1988. The effect of short supplies due to small harvests in the fall will be two-fold: (1) a large decrease in Federal deficiency payments to farmers; and (2) a reduction in Federal storage costs.

Deficiency payments are made to farmers according to the difference between the market price or loan rate, and target price levels. Here are the assumptions on which the Federal government planned to make deficiency payments on corn and wheat totalling $12.1 billion over the next three years.

BUDGETARY SAVINGS FROM THE DROUGHT, 1988–90

[In billions of dollars]

	Estimated Crop Loss		
	Minor	Moderate	Major
Savings from lower deficiency payments on wheat and corn	4.70	5.5	8.3
Savings from lower CCC storage and handling	0.5	0.7	1.3
Savings from lower farm storage payments	0.1	0.2	1.25
Total Savings	5.3	6.4	10.85

Minor = 50% loss of spring wheat/small grain, 15% corn.
Moderate = 60% loss of SW/SG, 25% corn.
Major = 80% loss of SW/SG, 50% corn.

At the beginning of FY 88, the Federal Government maintained a storage inventory of over 4.1 billion bushels of corn, 1.3 billion bushels of wheat, and 6.2 billion pounds of milk products. The annual cost of maintaining this stockpile of farm products was budgeted to be $600 million.

With the potential for major crop losses, withdrawals from surplus have proceeded at an amazing rate. It is possible that by the end of this year, carry over stocks for wheat will be 250 million bushels, and for corn will be 2 billion bushels. The combined cost savings to the Federal Government over the next three years could be as high as $10 billion.

So the total budgetary wind fall to the Federal Government for funds allocated which will not be spent could be $1 billion in the current fiscal year, $6 billion in FY89, and $3 billion in FY90.

C. Rural Development Fund

These resources should be placed in a drought relief rural development fund. These funds need to remain in rural areas, directed to urgent relief and long term development projects. The objectives of this fund should be to meet the short term, mid- and long-term needs of farm families, and to provide assistance to rural communities and businesses to help them recover from the negative impact the drought conditions had on them as well.

1. *Drought relief priorities* (for eligible producers only):

Short term:
- —Prompt approval of county EFP and EFAP requests
- —Waive repayment of advance deficiency payments (S. 2526)
- —Allow harvest of oats on setaside acres
- —Purchase distressed livestock as it comes on the market—use for domestic feeding programs
- —Eliminate USDA's authority to cut dairy supports (S. 2559)

Mid term:
- —Guarantee deficiency payments on failed production
- —Allow producers to plant on 100% of 1988/1989 crop base—no setaside
- —Assist producers of specialty and non-program crops

Long term:
- —Make FmHA Disaster Loans available to producers for the purpose of consolidating losses, purchasing livestock feed, and financing 1989 planting expenses
- —Forego any reduction in 1989 target prices
- —Restore income averaging for farmers (S. 1743)

It is our strongest hope that adoption of these proposals, at both the legislative and administrative level, will provide the targeted relief farmers in Minnesota and elsewhere need to continue operations. The limited assistance called for here will enable livestock operations to maintain their herds, dairy producers to continue milking their cows, grain producers to plant cover crops on barren land and small businesses and communities to weather the lingering problems that historically follow natural disasters.

Without this assistance, we can expect to see thousands of Minnesota farms, hundreds of small town businesses and dozens of lenders thrown back into the downward cycle of financial insolvency which was so devastating in the early and mid eighties.

2. *Rural economic development priorities:*

Assistance to rural businesses:

Funding increases and drought-relating language changes in:
- EDA revolving loan program grants
- EDA Title IX "Sudden and Severe Economic Loans"
- Rural Enterprise Zone Program (S. 1743)
- Farmers Home Business and Industry Loan Program
- Farmers Home Water and Waste Water grants and loans
- UDAG loans to rural communities.

Assistance to rural governments:

New programs and planning funds for drought stricken areas:
- Targeted Fiscal Assistance (S. 660)
- Tax exempt bonds for rural development (S. 1864)
- Regional development planning commission funding

The purpose of these program additions to provide an injection of funding in proven areas of benefit to rural communities, through both the public and private sectors. Each of these existing programs have an excellent track record in Minnesota and can make the most of limited Federal dollars. The new program recommendations, the TFA, rural enterprise, and tax exempt bond programs have been studies and discussed over the last several years, and show promise as part of a long term national rural development agenda.

IV. CONCLUSION

Rural economic development as a Federal policy has suffered because of the narrow way in which its problems have been defined. Approaches which equate "rural" with "farm" fail in the long run to meet the needs of either.

The rural economy is a complex system of basic industries, quality of life, and governance. Federal policy must appreciate that interconnection and provide integrated assistance to the related problems in those sectors.

The problems and opportunities of America's rural communities have become a matter of national interest over the last several years. As yet, however, that concern has not been translated into a coordinated national rural strategy. It is hoped that this preliminary report, and those that follow it will point us in the proper direction.

Rural communities have played an important part in the development of the United States. As producers of food, raw materials and resources, as well as values, leadership and spirit, rural communities have made an inestimable contribution. As America looks to its third century, those same materials and qualities will be just as important.

What is needed in Federal policy is an understanding of rural America's problems, respect and support for its solutions, and a commitment to cooperate in the effort to provide tools for coping with change in rural America. If the national government can do that, we can help shape a bold, vital rural future, which will serve the best interests of all Americans.

PREPARED STATEMENT OF CURTIS C. ERICKSON

Good morning Mr. Chairman, I am Curtis C. Erickson. I am pleased to testify on behalf of the Prospective Payment Assessment Commission. I am a member of the Commission, and I am accompanied this morning by Bruce Steinwald, Deputy Executive Director of the Commission. I am also the president and chief executive officer of the Great Plains Health Alliance, a group of rural hospitals in Kansas and Nebraska, so I am particularly familiar with the problems we are discussing at today's hearing.

The prospective payment system has had a number of both anticipated and unanticipated effects: some positive and, unfortunately, some negative. One of the negative unanticipated effects has been on small rural hospitals. Certainly PPS was not designed to discriminate against any group of hospitals, but because of a convergence of changes related to medical practice, reimbursement policy, technological advancements, and rural economics—to name the most important—rural hospitals have fared poorly under PPS.

Like others, ProPAC did not anticipate the extent to which rural hospitals would have major problems under the system. Probably the most serious problem experienced by rural hospitals has to do with their declines in admission and the fact that PPS is a volume-based per-case payment system. Hospitals with increases in patient volume are more likely to receive positive rewards from Medicare's prospective payment system. But over the last decade, as I will describe in more detail later in my Statement, rural hospitals have lost patients. Small rural hospitals have seen admission rates drop earlier and faster than other U.S. hospitals.

The Medicare prospective payment system is not the only problem. In addition to the significant decreases in admission rates and utilization of rural hospital services, there are several other important factors having an impact on rural hospitals. These include the increasing sophistication of medicine, the movement of services out of the hospital, referral of patients to larger hospitals for more complex services, and shortages of necessary medical personnel. In addition, the demographic and economic environment of rural communities is changing. An aging population, eroding patient base, and changing rural economy are among the additional forces influencing the long-term viability of rural hospitals.

I think that it is fair to say that ProPAC, along with many others, was slow to recognize the seriousness of these factors and their effects on the financial problems of rural hospitals. But, we have been trying to make up for our slow start by devoting considerable time and resources in the last few years to reducing these problems.

In the past several years we have undertaken special studies of hospital closures, concentration of services, readmissions and transfers, geographic cost variation, hospital utilization trends, rural hospital redesignation, urban-rural cost differences, and sole community and other isolated rural hospitals. All of these studies have produced information that we hope will assist in better defining and solving rural hospital problems, and we will continue to work in these areas.

Let me mention some of the general data and information we have gathered on rural hospitals. Then I will describe a few of our special studies.

DESCRIPTIVE DATA ON PPS AND RURAL HOSPITALS

Hospitals located in rural areas make up about 48 percent of all U.S. hospitals, but they provide care for about 24 percent of the Medicare patients. They receive 16 percent of all PPS payments. Rural hospitals receive 8 percent of total outlier payments, 2 percent of teaching payments, and 2 percent of disproportionate share payments. Table 1 shows these distributions.

The differences between urban and rural hospitals reflects the smaller size of these hospitals as well as the less complex mix of cases they treat. For each year of PPS, average PPS operating margins have been substantially lower for rural hospitals than for urban hospitals, as shown in Table 2. In the first year of PPS, rural hospital operating margins were 8.4 percentage points lower than urban hospitals. This difference decreased to 6.9 percentage points by the fourth year of PPS, when the average rural PPS margin was -0.6 percent. We anticipate that all hospital margins may be even lower in the fifth and sixth years of PPS and that rural hospitals' margins may continue to be lower than the average margins for all hospitals.

An examination of the distribution of PPS operating margins shows that 10 percent of rural hospitals experienced negative margins of −34 percent or lower in the fourth year of PPS (Table (3). Twenty-six percent of rural hospitals had negative PPS margins for three or more years of PPS.

Since the third year of PPS, however, when initial PPS data began to be available, rural hospitals have been the primary beneficiary of PPS policy changes. Policy changes that you enacted to take effect in fiscal years 1987, 1988, and 1989 led to a 10.2 percent increase in rural hospitals payments compared with 5.1 percent for urban hospitals. (Table 4). These policy changes included a higher update factor, discharge-weighted payment rates, and separate urban and rural outlier pools. Rural hospitals received a higher update factor in fiscal years 1988 and 1989. ProPAC has also recommended a higher update factor for fiscal 1990, which we hope will be favorably considered. In spite of higher rural updates and other policy changes, per-case PPS payments to rural hospitals have not generally increased as much as anticipated. This is because rural hospitals treat a less complex mix of patients compared to urban hospitals, and case-mix has been a major source of payment increases.

It is important to note, however, that while rural hospitals have lower payment rates than urban hospitals, rural hospitals also have much lower costs than urban hospitals. Rural hospitals have average Medicare costs per case that are about 40 percent lower than urban hospitals. This cost difference existed before PPS, and has continued at about the same level through the present time. It is parallel to the approximate 40 percent difference in average PPS per-case payments between rural and urban hospitals.

Rural hospitals differ from urban hospitals in a number of important ways, especially in the impact of changes in admission rates and occupancy rates. As I mentioned before, utilization of hospital care in the U.S. has declined substantially during the last decade. These declines are caused by the fact that fewer patients are admitted to hospitals, and those that are admitted stay for shorter lengths of time. Fewer patients are admitted because medical patterns of practice have changed and because technology has allowed many procedures to be done more quickly, easily and safely in outpatient settings. These factors have also worked to decrease length of stay.

The decreases in utilization are extremely dramatic for patients under 65, and these decreases began some time ago. Utilization decreases are also very significant for aged Medicare beneficiaries, however. The average number of Medicare cases per hospital per year decreased rapidly for both urban and rural hospitals from 1984 to 1987, as seen in Table 5. These decreases have been felt disproportionately among hospitals. The rate and duration of the decline in admissions and occupancy has especially affected rural hospitals. The decline in admissions began for rural hospitals in 1981, but did not begin for urban hospitals until 1984. In addition, the rate of decrease for rural hospitals was almost 3 times larger than the rate for urban hospitals from 1984 to 1987. (See Table 6). For the smallest urban and rural hospitals, rates of decrease frequently have been twice as large as the rates for all urban and rural hospitals. Thus, the magnitude of this decline in inpatient volume has been much greater for small urban and rural hospitals than for any other hospital groups.

As a result, many small rural hospitals have suffered. Reductions in admissions are particularly difficult under PPS. Under the earlier cost reimbursement system, Medicare paid for its share of the costs of maintaining beds, even if these beds were not used. Under PPS, the hospital receives no payment unless a patient is admitted. Thus, at a time when admissions are falling in small hospitals and in rural hospitals, it is the smallest rural hospitals that are most likely to be negatively affected. This becomes a vicious circle—because of their small size and low occupancy, rural hospitals are not able to provide new and complex services in a manner that is both cost efficient and enhances quality of care.

A ProPAC study just completed reviews hospital readmissions and transfers in the years 1984, 1985, and 1986. Our study found that both readmission and transfer rates differed significantly among hospital groups. Readmission rates varied by urban and rural location and by number of hospital beds. Rural hospitals and smaller hospitals had higher rates of readmission than did their urban counterparts. Transfer rates showed even more variation between types of hospitals. Rural and small hospitals have higher transfer rates than do larger urban hospitals. The smallest rural hospitals, those with less than 50 beds, had the highest transfer rates of any group of hospitals.

We believe that these findings indicate that appropriate referral is taking place in smaller U.S. hospitals, and that patients who need high technology intensive care—care that cannot be available in every U.S. hospital—are being transferred to appropriate locations.

Another important change is that more rural hospitals are now receiving reimbursement for care delivered in swing beds. As you know, this program was designed to address the shortage of nursing home beds in rural areas and the low occupancy in rural hospitals. Swing bed hospitals can use beds interchangeably to furnish either acute care or skilled nursing facility-type services to Medicare beneficiaries.

The number of hospitals participating in the swing bed program increased from 149 in 1983 to over 1,000 by July 1987, according to HCFA data. As of 1986, HCFA reported that about half of the eligible rural hospitals were participating in the swing bed program. The number of admissions has increased considerably in these beds, and it is likely that the swing bed program has improved access to SNF services for rural residents. HCFA has recommended continuation of the program and consideration of extending the option to larger hospitals. This extension may be a useful policy option for consideration in the face of the rural hospitals problems we are discussing today.

CLOSURE STUDY

An analysis prepared for ProPAC under contract studied hospitals that closed from 1980 to 1987. Figure 1 shows the 363 hospitals that, according to AHA statistics, closed by rural and urban location. Additional data was available for 248 of these hospitals. For these, our analysis reviewed general characteristics of the closed hospitals, comparing them with general characteristics of all hospitals and with hospitals of similar size.

Generally, this study found that closed hospitals were more likely to be small. They had fewer admissions and lower occupancy rates than open hospitals in the year prior to closure, and they had higher costs and longer lengths of stay than hospitals that remained open. Slightly less than half of the closed hospitals were in rural areas—about 51 percent were in urban locations.

ProPAC staff analysis of PPS margins for closed hospitals showed that a vast majority of them had negative PPS margins in one or more years prior to closure, and that these PPS margins tended to fall among the lowest for all hospitals. However, not all closed hospitals had negative PPS margins. Some had sizable margins, even up to the year prior to closure. For these hospitals, other factors must have contributed to closure.

Other studies related specifically to closure of rural hospitals have found that counties in which closed hospitals were located had almost twice as many beds as there were in counties where similar hospitals remained open. In interviews, administrators of rural hospitals that closed in 1987 indicated that Medicare PPS was only one of many factors contributing to closure. Less than half of those interviewed cited PPS as a factor related to closure.

PROPAC RECOMMENDATIONS AND PLANS

ProPAC has, as noted, recommended a higher update factor for rural hospitals for the last three years. In addition, we have urged the Secretary to complete mandated studies, and to evaluate and clarify sole community hospital policies and criteria. In our report and recommendations to the Secretary of HHS this year, we again expressed our concern about the problems affecting rural hospitals and the rural health care system, particularly as they relate to access to services.

Because we consider access to care in rural areas a critical concern, ProPAC has planned an extensive agenda for future analytic activities in this area. This agenda includes a series of projects that we anticipate will produce useful information to help address and better understand rural health and the problems facing rural hospitals.

We are expanding our study of hospital closures, to gather and assess additional information about why hospitals close and the effect of these closures on the community. Hospital closure may be appropriate where other hospitals remain open in the area. In such cases, closure and consolidation of services can be more efficient and can also result in higher quality care.

We will also undertake studies of where hospital patients come from, called patient origin studies. We will continue our analysis of payments, costs, and margins. We have begun a major research project to review Medicare costs over time and across different types of hospitals.

The information from these studies will allow ProPAC to consider several important policy options in coming months. Among these are elimination of separate urban-rural standardized amounts; continuation of urban-rural differential updates to bring the two standardized amounts closer together; establishment of special payments to rural hospitals, both related and unrelated to PPS; and development of a payment mechanism other than PPS for some small rural hospitals.

CRITICAL ISSUES

Many critical policy questions must be examined in order for informed decision-making to take place in this area. Some of these extremely important questions include:

How much of the rural hospital problem is the result of Medicare policy? How much responsibility does Medicare have to assure that existing rural hospitals remain open?

Should some type of volume adjustment be added to PPS to compensate for the negative impact of PPS on rural hospitals?

What is the impact of hospital closures on rural residents? Are these residents not receiving care at all, or are they receiving care elsewhere?

How should we define access? What criteria should be used—geography, extent of services, other?

What is the minimum package of services needed to maintain access and is this the optimal package of services?

It may be that we need to develop new ways to thinking about these subjects. The traditional rural hospital, as we have known it, may not be appropriate for delivery of high technology, intensive services. Yet rural residents have certain medical needs that can and should be met locally. There is a great need for research and demonstration on new methods of health care delivery, such as the effort underway in Montana. Innovation is needed to strengthen and adapt health care delivery to meet the changing needs of rural communities and to respond efficiently to changes occurring in medical practice. ProPAC believes that rural health care is a critical policy problem. Work in this area will be an extremely high priority for our agenda in the next year. We will continue to work with the Committee on this subject as our research is completed. Mr. Steinwald and I will be glad to answer any questions you may have at this time.

Enclosures.

TABLE 1.—DISTRIBUTION OF HOSPITALS, DISCHARGES, AND PPS PAYMENTS, BY HOSPITAL GROUP

[In Percent]

Hospital Group	Hospitals	Medicare Dis-charges	Total PPS Payments	Teaching Payments	Disapro-portionate Share Payments	Outlier Payments
All hospitals	100	100	100	100	100	100
Urban	52	76	84	98	98	92
Rural	48	24	16	2	2	8
Rural referral	4	6	5	2	0	3
Sole community	6	2	1	0	0	0
Other rural	38	15	9	0	1	4
Rural <50 beds	23	4	2	(1)	(1)	1
Rural 50–99 beds	14	7	4	(1)	1	1
Rural 100–169 bed	7	6	4	(1)	(1)	2
Rural 170+ beds	4	7	5	2	(1)	4

[1] Less than 0.5 percent.

Note: PPS payments simulated using FY 1989 policy rules, including changes resulting from implementation of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360. Columns may not add to 100 due to rounding or missing values.

Source: ProPAC simulations using FY 1987 MedPAR data from the Hearth Care Financing Administration.

TABLE 2.—PPS OPERATING MARGINS FOR THE FIRST FOUR YEARS OF PPS, BY HOSPITAL TYPE

[In percent]

Hospital Group	PPS 1	PPS 2	PPS 3	PPS 4
All hospitals	14.3	14.4	9.4	5.2
Urban	16.4	15.5	10.4	6.3
Rural	8.0	8.8	3.2	0.6
Rural referral	9.4	14.2	8.7	4.0
Sole community	6.5	7.1	1.8	−1.8
Other rural	7.7	6.5	0.2	3.3
Rural <50 beds	5.7	5.8	−1.8	−3.0
Rural 50-99 beds	8.3	7.5	2.0	−1.6
Rural 100-169 beds	8.4	8.2	2.5	0.9
Rural 170+ beds	8.7	12.2	6.8	1.2

Note: Excludes hospitals in Maryland and New Jersey. Massachusetts and New York hospitals are included beginning in PPS 3.

Source: ProPAC estimates using Medicare Cost Report data from the Health Care Financing Administration.

TABLE 3.—FOURTH-YEAR PPS OPERATING MARGINS: MEANS AND PERCENTILES, BY HOSPITAL GROUP

Hospital Group	Mean	Percentile				
		10th	25th	Median	75th	90th
All hospitals	5.2	−24.4	−9.5	1.6	10.6	18.3
Urban	6.3	−16.3	−5.3	4.4	12.8	19.7
Rural	−0.6	−33.9	−13.9	−2.0	7.4	16.0
Rural referral	4.0	−12.0	−4.0	4.0	11.7	16.6
Sole community	−1.8	−44.0	−19.3	−3.7	6.6	14.9
Other rural	−3.3	−35.4	−15.0	−2.5	6.9	16.0
Rural <50 beds	−3.0	−49.3	−23.1	−3.2	8.5	19.1
Rural 50–99 beds	−1.6	−22.1	−11.4	−1.6	6.6	13.3
Rural 100–169 beds	−0.9	−21.2	−9.9	−1.4	6.6	14.6
Rural 170+ beds	1.2	−16.4	−8.1	−1.3	7.8	14.3

Note: Excludes hospitals in Maryland and New Jersey.

Source: ProPAC estimates based on Medicare Cost Report data from the Health Care Financing Administration.

TABLE 4.—EFFECTS OF PPS UPDATE FACTORS AND OTHER POLICIES ON PER-CASE PPS PAYMENTS TO HOSPITALS

[In percent change]

	Payment Policy Years (In percent)						
	1985	1986[1]	1987	1988[2]	1989[3]	Total[4]	Total with Case-Mix[5] Change
All hospitals	5.9	0.9	0.7	2.4	2.6	13.9	42.2
Urban	5.9	1.0	0.4	2.1	2.5	13.4	43.1
Rural	5.5	0.5	2.2	4.3	3.4	16.9	39.5
Rural referral	8.7	0.9	2.4	3.4	2.3	22.8	49.4
Sole community	5.6	0.5	1.8	3.2	3.5	12.6	32.7
Other rural	4.6	0.3	2.3	4.7	4.0	16.0	37.1
Rural <50 beds	7.3	1.1	4.5	7.6	4.2	29.2	48.3
Rural 50–99 beds	5.1	0.7	2.7	5.5	3.7	18.3	39.2
Rural 100–169 beds	4.9	0.6	1.9	4.0	3.0	14.9	38.8
Rural 170+ beds	5.6	−0.2	1.1	2.0	3.0	12.2	36.4

Note: Figures are not estimates of actual changes in fiscal year PPS hospital payments. Payments are simulated to isolate the effects of changes in PPS policies during the first six years of PPS. The effects on payment of changes in length of stay and volume are not included. Except for the last column, case-mix index change is also excluded. New York and Massachusetts are included beginning in 1987.

[1] 1986 column simulates payments under a full year of COBRA policies, which did not take effect until May 1988. The 1.0 percent Gramm-Rudman payment reduction in effect from March 1, 1986 through September 30, 1986 is not included.

[2] 1988 column simulates a full year of COBRA 1987 policies, which did not take effect until April 1988. Also included is the teaching reduction, which will not actually be implemented until FY 1989.

[3] 1989 column includes the effects of the Medicare Catastrophic Coverage Act of 1988.

[4] Total includes 1984 effects of transition to national rates, which is not shown in year-by-year columns.

[5] The last column adjusts the total to include estimated case-weighted CMI change from 1983 to 1989. Variation in CMI change across hospital groups was measured from 1981 to 1987. An across-the-board adjustment was made for other years.

SOURCE: ProPAC simulations based on data from the Health Care Financing Administration.

TABLE 5.—ANNUAL PERCENTAGE CHANGE IN AVERAGE MEDICARE CASELOAD PER HOSPITAL, BY LOCATION AND SIZE

[In percent]

Fiscal Year	Urban Hospitals		Rural Hospitals		
	All	<100 Beds	All	<50 Beds	50–99 Beds
984	−5.9	−8.4	−7.8	−10.3	−8.4
985	−5.3	−8.6	−7.8	−10.5	−8.8
986	−2.6	−5.1	−5.2	−7.3	−5.4
987	−0.5	−2.6	−2.2	−4.8	−2.5
Average 1984–1987	−2.8	−5.6	−5.1	−7.6	−5.6

Source: ProPAC tabulations of Medicare discharges reported on hospitals' Medicare Cost Reports for reporting periods beginning during each Federal fiscal year.

Table 6.—ANNUAL PERCENTAGE CHANGE IN TOTAL ADMISSIONS AND AVERAGE ADMISSIONS PER HOSPITAL FOR URBAN AND RURAL COMMUNITY HOSPITALS

[In percent]

Year	All Community Hospitals[1]			Open Community Hospitals <200 Beds[2]		
	all	Urban	Rural	All	Urban	Rural
1980	3.0	2.9	3.1			
1981	0.8	3.5	−7.4	−0.6	0.8	−2.8
1982	−0.2	0.1	−0.9	−1.4	−0.9	−1.7
1983	−0.6	0.7	−5.2	−3.0	−2.0	−4.3
1984	−2.8	−2.0	−5.3	−3.7	−2.9	−4.1
1985	−4.9	−3.9	−8.4	−6.1	−3.6	−8.4
1986	−3.2	−2.3	−6.8	−4.5	−1.8	−7.3
1987	−2.4	−1.6	−5.7			
Averages:						
1979–1987	−1.3	−0.4	−4.6	[3] −3.2	[3] −1.7	[3] −4.8
1979–1983	0.7	1.8	−2.7	[4] −1.7	[4] −0.7	[4] −2.9
1984–1987	−3.5	−2.6	−7.0	[5] −5.3	[5] −2.7	[5] −7.8

[1] ProPAC calculations from unpublished tabulations by the American Hospital Association of Annual Survey data.

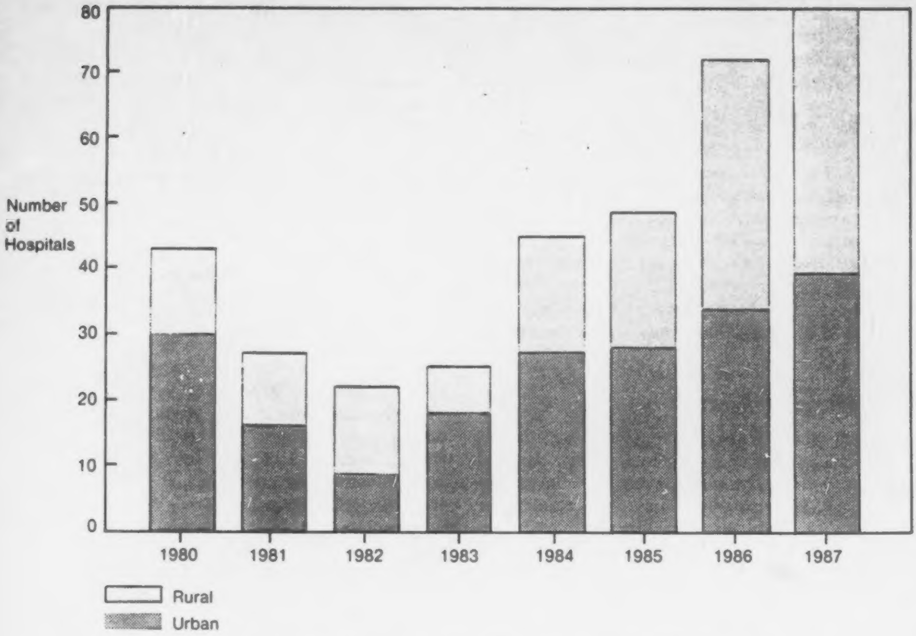
[2] These figures give annual percentage changes in admissions per hospital in hospitals that remained open each year. Based on tabulations of American Hospital Association Annual Survey data prepared for ProPAC by Jack Hadley, Ph.D.

[3] 1980-1986

[4] 1980-1983

[5] 1984-1986

Figure 1. Community Hospital Closures, 1980–1987



SOURCE: Ross Mullner, Ph.D., David Whiteis and David McNeil "More Hospitals Close in 1987," Center for Health Services Research, School of Public Health, University of Illinois at Chicago, February 22, 1988

RESPONSES TO QUESTIONS SUBMITTED BY SENATOR HEINZ

Question. If we raised rural rates to the urban level, to what extent would this change the financial forecast for rural hospitals? What, for example, would be their profit margins after 2-5 years? Can and should we expect to keep all rural hospitals open?

***Answer.* If the differential in the standardized amounts was eliminated, the rural hospital base payment would increase on the order of 10 to 12 percent (depending upon budget neutrality). The following table shows the distribution of PPS operating margins for the fourth year of PPS (mostly 1987).**

TABLE 1.—FOURTH-YEAR PPS OPERATING MARGINS: MEANS AND PERCENTILES, BY HOSPITAL GROUP

Hospital Group	Mean	Percentile				
		10th	25th	Median	75th	90th
All hospitals	5.2	−24.4	−9.5	1.6	10.6	18.3
Urban	6.3	−16.3	−5.3	4.4	12.8	19.7
Rural	−0.6	−33.9	−13.9	−2.0	7.4	16.0
Rural referral	4.0	−12.0	−4.0	4.0	11.7	16.6
Sole community	−1.8	−44.0	−19.3	−3.7	6.6	14.9
Other rural	−3.3	−35.4	−15.0	−2.5	6.9	16.0
Rural <50 beds	−3.0	−49.3	−23.1	−3.2	8.5	19.1
Rural 50-99 beds	−1.6	−22.1	−11.4	−1.6	6.6	13.3
Rural 100-169 beds	−0.9	−21.2	−9.9	−1.4	6.6	14.6
Rural 170+ beds	1.2	−16.4	−8.1	−1.3	7.8	14.3

Note: Excludes hospitals in Maryland and New Jersey.

Source: ProPAC estimates based on Medicare Cost Report data from the Health Care Financing Administration.

The table indicates that at 1987 levels of payment, a 10 to 12 percent increase would still leave a substantial fraction of rural hospitals with negative PPS margins. Because there is a wide dispersion of margins, many rural hospitals are earning profits under PPS, and those profits would become substantially larger.

If the payment differential were eliminated in a budget-neutral fashion, urban hospitals would have their base payments reduced by nearly 2 percent.

There exist no hard data on the financial picture at present or in the next 2 to 5 years. Actions taken by Congress, not reflected in the table, have already narrowed the gap between urban and rural hospital financial performance under PPS. At the same time, our data suggest that this performance has probably worsened for both urban and rural hospitals, on average, so that an even larger fraction of rural hospitals are experiencing negative margins at present.

Future margins depend both on levels of payment and increases in payments and the trend in costs per case. ProPAC believes that, since recent inpatient cost increases have been abnormally high, the financial health of both urban and rural hospitals depends, in part, on hospitals' ability to bring these costs under control.

ProPAC has indicated that we do not believe all rural hospital problems are caused by Medicare or can be solved by Medicare changes alone. Thus we do not believe it is appropriate to expect to keep all existing rural hospitals open as acute care inpatient facilities if their problems have multiple origins. This is especially true for most areas where there is another hospital nearby.

Question. If we take any steps to provide relief to certain rural hospitals—such as those dependent on Medicare for 70% or more of their revenues—other categories of hospitals will quickly cue up to say "me too." We'll need hard data on which to assess their appeals.

What data does ProPAC have on the impact of PPS on other categories of rural and urban hospitals—such as urban and large urban hospitals—that are heavily depndent on Medicare or on Medicare and Medicaid collectively? What are the profit margins of these hospitals with and without additional adjustments (such as disproportionate share) factored in?

Answer. ProPAC has analyzed PPS operating margins (or profit margins) for hospitals that had varying proportions of Medicare patient days as a percentage of total patient days. Proportions ranging from less than 25 percent to greater than 65 percent are shown below. This particular analysis does not break out rural and urban

location, nor do we have data on both Medicare and Medicaid share of days. We are conducting such an analysis and will have this information early this summer.

TABLE 2. PPS OPERATING MARGINS FOR THE FIRST FOUR YEARS OF PPS, BY HOSPITAL GROUP

[In percent]

Hospital Group	PPS 1	PPS 2	PPS 3	PPS 4
All hospitals	14.3	14.4	9.4	5.2
Urban	16.4	15.5	10.4	6.3
Rural	8.0	8.8	3.2	−0.6
Medicare days as a percentage of total days:				
<25%	17.1	18.3	14.0	11.9
25%-50%	15.2	15.5	10.6	6.3
50%-65%	13.5	13.3	8.0	1.7
>65%	12.5	9.7	4.3	−1.9

Note: Excludes hospitals in Maryland and New Jersey; hospitals in Massachusetts and New York included beginning in PPS 3.

SOURCE: ProPAC estimates using Medicare Cost Report data from the Health Care Financing Administration.

ProPAC's calculations of PPS operating margins include all adjustments (such as teaching and disproportionate share) but exclude pass-through payments (such as capital). We cannot determine what margins would be in the absence of the indirect medical education and disproportionate share adjustments. As the system was designed, however, funds for these payments, which go primarily to urban hospitals, were taken from the base payment amount for urban hospitals. Therefore, these adjustments redistribute payments primarily within urban areas, rather than from rural to urban hospitals.

Question. The Commission is conducting a study of how Medicare should fairly reimburse rural hospitals that border urban areas and are eligible to receive an urban rate—an issue this Committee has struggled with for some time.

What are your findings and conclusions so far? I'd also like your views on how we should deal with hospitals that have been and may yet be subjected to substantial and unintended cuts as a result of HCFA's previous and your pending recommendations in this respect.

Answer. ProPAC does not yet have any preliminary findings on the rural redesignation study. The Commission has approved the analytical framework for the study and will look at the effects of a set of policy options: prior law, current law, TAMRA policy, current law with added criteria, ProPAC recommended labor market areas, and a blended wage index. Preliminary findings are expected by mid-June. The final report will be submitted to Congress in August.

RESPONSES TO QUESTIONS SUBMITTED BY SENATOR ROCKEFELLER

Question. You have testified that rural hospitals have fared poorly under the prospective payment system. On *Table 1.* in your testimony, you present figures on the distribution of various payments by hospital type.

As you know, "disproportionate share" payments are given to those hospitals that serve a disproportionate share of low income patients to compensate them for the "extra" costs of treating poor patients.

I note that rural hospitals receive only 2 percent of total "disproportionate share" payments. Small rural hospitals with less than 50 beds essentially receive no disproportionate share payments. In order to qualify for these payments *urban* hospitals' proportion of low-income patients must be at least *15 percent.* A *rural* hospitals' proportion must be at least 45 percent.

I wrote to ProPAC about this issue in the past and was told that service to the poor raises Medicare costs for hospitals in urban areas and that only rural hospitals with an exceptionally high percentage of poor and Medicare-Medicaid crossover patients had higher Medicare costs per case as a result of service to the poor.

17 percent of *rural* Americans are uninsured, in comparison 14 percent of *urban* Americans are uninsured. Only ¼ of the rural poor qualify for Medicaid, compared to 43 percent of the poor in inner cities. A disproportionate share of the rural population is poor.

Mr. *Erickson,* I contend that this is another example of rural hospitals not receiving an adjustment that they need just as much as urban hospitals simply because they are *rural.* If it costs urban hospitals more to take care of low-income persons, I assert that it also costs more for rural hospitals to take care of low income persons.

Answer. It is true that to qualify for disproportionate share payments, urban hospitals must have a "DSH patient percentage" of 15 percent while for rural hospitals it is 45 percent. The formula which Congress established for calculating the DSH adjustment uses Medicaid and Supplemental Security Income (SSI) as markers of low income status. Studies done prior to the enactment of the DSH adjustment determined that it was at the 15 percent threshold for urban hospitals and 45 percent threshold for rural hospitals that costs increased for treating the DSH patient percentage. As the system was designed, funds for disproportionate share payments, which go primarily to urban hospitals, were taken from the base payment amount for urban hospitals. Therefore, these adjustments redistribute payments primarily within urban areas, rather than from rural to urban hospitals.

ProPAC plans to examine DSH adjustments in the coming year. Staff will be looking at the incremental change in costs and the differential thresholds for both rural and urban hospitals.

Your other point regarding the uninsured is correct. As you know however, the DSH adjustment enacted by Congress was never intended to compensate hospitals for care of the uninsured. The issue of unisurance for both rural and urban residents remains a serious and unresolved problem facing our nation.

RESPONSES TO QUESTIONS SUBMITTED BY SENATOR MITCHELL

Question. I certainly agree with your Statement that a volume-based reimbursement system like PPS disadvantages hospitals with declining admissions, but why have rural hospitals seen such a greater decline in patient admissions than hospitals in general? Are Medicare beneficiaries going elsewhere for care? Or is the more rapid decline a result of fewer private pay and /or Medicaid admissions?

Answer. There are many reasons for declining admissions. Part of the change is due to the fact that some care that was once rendered on an inpatient basis has largely moved to an outpatient basis—cataract surgery is an example of this. Another reason that especially affects rural hospitals is that more complex cases are often referred to large referral centers or to urban hospitals. An example of this would be coronary artery by-pass surgery. Still other contributing factors include changing demographic and economic environments of rural communities.

Some studies have suggested that younger, and well-insured rural residents may by-pass rural hospitals, leaving the poor and aged to seek care in the local rural institution. To the extent that this suggestion is accurate, erosion of a rural hospital's patient base results.

ProPAC has approved a grant that will examine the elderly rural residents' use of hospital care. Among other things, the study will document where rural Medicare beneficiaries obtain hospital care—whether at the local rural hospital or elsewhere.

Question. You mention that over the next few months you will be studying the recent closures of hospitals and analyzing the causes. When will you have that study ready for our review.

Answer. The study will be completed in June. As we indicated in our testimony, preliminary findings indicate that hospitals that closed tended to be small and had 31 to 61 percent fewer admissions and 17 to 38 percent lower occupancy rates than open hospitals in the year prior to closure. Closed hospitals had costs that ranged between 10 and 51 percent higher than open hospitals' costs; and their lengths of stay were between 3 and 26 percent higher. Slightly less than half of the closed hospitals were in rural areas—about 49 percent.

Analysis of PPS margins of closed hospitals by ProPAC staff found that a vast majority of them had negative PPS margins in one or more years prior to closure. PPS margins for these hospitals tended to fall among the lowest for all hospitals. However, not all closed hospitals had negative PPS margins. Some had sizable margins even up to the year prior to closure.

Other studies of the closure of rural hospitals have found that counties in which closed hospitals were located had almost twice as many beds as there were in counties where similar hospitals remained open.

Question. You mention new ways of thinking about the delivery of acute care services in some rural hospitals. While I think that this is important and worthy of substantial consideration, do you think that there are significant dangers here for a two-tiered health care system if we remove current levels of technology and physician oversight from rural hospitals?

Answer. A variety of research and demonstration projects are underway throughout the country. These projects are demonstrating, and analyzing, new ways to maintain access to high quality health care for rural residents, given our changing health care environment. Both publicly and privately funded, many of these projects involve innovative plans to strengthen or adapt health care delivery to meet the changing needs of rural communities. By initiating these projects on the small scale of a demonstration project, full assessment is possible in order to determine if any threat to access or quality of care is present.

We do not think that improvements in the way services are delivered and financed in rural areas would result in a two-tiered system. Rather, such changes would give hospitals and doctors more flexibility to furnish the services that are most needed in rural areas in a cost-efficient manner that will also improve quality of care.

As we develop new methods of delivery of care, it is important to concurrently review our mechanisms of quality assurance. In the past, ProPAC has examined reported perceptions of adverse quality of care and is not convinced that there is evidence of systematic problems. Because of the importance of quality of care, we believe that PRO monitoring of quality of care should be enhanced, expanded, and modified as new types of care and delivery mechanisms are developed and used.

PREPARED STATEMENT OF KEVIN FICKENSCHER

Mr. Chairman and Members of the Committee. My name is Kevin Fickenscher, M.D. I am the Director of The Center for Rural Health of the University of North Dakota. The Center is a nationally recognized program involved in providing services for rural communities throughout the Midwest and West, conducting research on important rural health concerns, and performing policy analysis from a rural perspective.

I would like to begin by thanking you for allowing me the opportunity to testify before the U. S. Senate Finance Committee. I would also like to extend my gratitude to the Members of the Committee for holding hearings on the important issues which affect the viability of rural hospitals. Your attention to the concerns of the rural health community over the last several years have had an important impact on the Medicare debate. The ideas advocating attention to the need for equity in payments for rural hospitals and physicians are receiving increased attention.

I can think of no other time in the recent past where the concerns of rural America have been heard by such large number of the Members of both the Senate and House. In particular, I am heartened by the introduction of S. 306, the Equity for Rural Hospital Act, by Senators Bentsen and Dole which begins to redress the inequities in our current reimbursement system.

Those of us who are involved in rural health clearly recognize the difficult task that the Members of Congress face in balancing the need to gain control of Federal health care expenditures with the need to insure access to basic services for both urban *and* rural people. The need for balance in our health care system is a crucial discussion which is too often neglected.

I am here advocating equity while recognizing the fact that some rural hospitals should be allowed to close. I am advocating change in the Medicare reimbursement system while recognizing that it has fostered innovation in our approach to the delivery of health care in many rural sections of the nation. I am advocating integration in the face of inherent pressures within our health care system which discourage such efforts for sustaining access to local health care services.

I do not believe that we should engage in a game of institutional (i.e. rural hospital) support simply to guarantee institutional survival. The rural health care system and the very existence of many rural hospitals are, indeed, jeopardized. But the jeopardy of these institutions should not be our primary concern. Rather, the basic question should be: What will happen with access to health care without these facilities in the rural areas of the nation? Above all else, we must consider the impact of our policies on the ability of rural people to gain access to a basic set of health care services.

One of the most positive outcomes of the last decade of changes in the reimbursement system for health care is the recognition that the flow of dollars will determine the shape of our health care system. If we invest in acute care, we will get it. A payment system that emphasizes outpatient, ambulatory care will give us such care. If we pay rural hospitals substantially less than urban hospitals for exactly the same services, they will close. I believe this is an essential lesson for the policymakers designing solutions to the problems within our nation's health care delivery system.

It's time to move beyond equity to the more perplexing issues of what type of system do we want? How can the formulas of our reimbursement system be revised to assist in shaping the health care system we want and need for the nation?

As many of you are aware, I am also a member of the National Advisory Committee on Rural Health which reports to Secretary Sullivan on issues related to the rural health system. It is anticipated that a series of recommendations will be made in the next several weeks related to equity in reimbursement. As part of those recommendations, we are considering a number of parameters which are important elements of a Federal Medicare reimbursement system. These preliminary ideas include:

- implementation of a short-term stabilization of the rural hospital reimbursement situation while concurrently pursuing a more long-term solution.
- replacement of the urban-rural Prospective Payment System (PPS) payment differential with a single national rate, adjusted for severity of illness and other cost factors beyond the control of an individual hospital.
- recognition that arbitrary splintering of the health care system along geographic lines results in inequities of access to basic services.
- definition of "essential access facilities" over the next several years with local community and State involvement in defining these facilities under Federal parameters.
- acceptance that some rural hospitals should be allowed to close.
- facilitation of integrated and innovative service delivery at the local level through reforms adapted for the health care financing reimbursement system.

These basic elements then represent a basis for future policy deliberations on health care. Before proceeding with some specific examples, I would like to concentrate on the issues of integration and innovation which have too often been neglected in the health care debate. Rural hospitals must adapt to the changes in the health care environment. But we cannot expect change without having in place a reimbursement system that not only recognizes but encourages change. Once again, I return to the argument that where the emphasis is placed in our health care dollar will determine the shape of the health care system. Specific concepts that should be encouraged as part of those reimbursement changes include:

- encouraging changes in the fundamental mission of the rural hospital when the full complement of services traditionally reserved for the hospital may not be required for providing access to basic services within the community.

In 1987 the Montana State Legislature passed legislation creating a new type of rural health care facility, the Medical Assistance Facility, for frontier (i.e. less than six people per square mile) regions of the State. The idea is under development through a grant from the Health Care Financing Administration (HCFA) to the State hospital association. These facilities will provide care for less than 96 hours. In addition, services will be more limited than a full-fledged hospital by providing only basic inpatient medical services without surgical or obstetrical services. Staffing will be provided by Physician's Assistants and Nurse Practitioners under protocol with mandatory linkages to a referral center. It appears that the "MAF" provides a viable option for some rural communities who need to sustain access to a set of basic services. Although the concept has substantial merit, I believe we are limiting the utility of the concept by only allowing one State to develop these facilities and then, only in frontier settings. I would suggest that we need to:

(1) require HCFA to allow for greater experimentation with the MAF concept by including more States in the demonstration phase.

(2) encourage development of these facilities in more traditional rural areas rather than restricting them to solely frontier regions of the nation.

(3) allow flexibility at the State level in determining the composition of services provided within these rural facilities. By creating an experimental environment at this time, we will have a better opportunity to assess the capability of the MAF to deliver needed services in rural areas.

(4) restrict the development of these facilities to only rural areas. HCFA is concerned that the concept could be applied in many different settings and only contribute to an escalation of health care costs. By restricting the notion to rural areas, we can foster an environment of support for the concept without encouraging development of an untested program.

(5) require State involvement in the development of these facilities under Federal parameters.

- reducing an emphasis on acute care by facilitating diversification into other service areas.

Many examples of diversification are evident in rural health care settings. Some of the most important are those efforts which extend services to the elderly. One example includes the Geriatric Resource Center in Arizona. Case management activities are the central focus of the program which is designed to provide a continuum of care including medical care, nutritional support, social services, in-home services and assistance in determining the appropriate level of care required for individual elders. The project is presently funded by funds from a local foundation. The major limitation of further development of such a concept in other rural areas is funding. We need to:

(1) support legislation that encourages a comprehensive evaluation of case manager systems in rural settings.

(2) recognize that our current system supports funding of acute care with little support for less traditional services.

- placing a priority on the development of networks with other rural hospitals to share services and reduce costs;

The Affordable Rural Coalition for Health (ARCH) project attempted to develop such networks in North Dakota, Colorado and Montana. In many respects the most successful elements of the project included those areas where communities within a given region were required to work together. Autonomous rural hospitals within a given geographic region are now working together to provide services such as mental health, respiratory care and dietary services at reduced cost. To encourage further development of such an approach we must:

(1) recognize that there are no incentives in our present reimbursement system which encourage networking of services between rural hospitals. Once again, if the incentives are present, we will realize even more experimentation.

(2) redefine the notion of "community" to include multiple rural communities and, the notion of "hospital" to be several institutions working together in a network with actual services provided at several different institutions.

- fostering the development of relationships with larger health care providers to improve the quality and scope of services; and,

A number of cooperative programs have been established throughout the nation. One example is the Western New York Health Care Cooperative which includes 13 hospitals, a medical school, a nursing home and two sub-hospital systems. The cooperative is attempting to consolidate obstetrical and pediatric services within an 8 county region, convert excess acute care bed capacity and develop a regionalized quality assurance program with a centralized, regional medical credentialing process. The effort is funded through a grant from the Robert Wood Johnson Foundation. Other similar examples are evident in Maine, Wisconsin, Texas, Kansas and other rural areas throughout the nation.

- encouraging linkages in the various components of the health care system at the local level.

One of the most innovative efforts in developing local linkages between different parts of the health care system is the West Alabama Rural Health Consortium, once again funded by the Robert Wood Johnson Foundation. The consortium consists of five rural hospitals, one referral hospital, a federally-funded community health center, six county health departments, three county nursing homes, a medical school and a community college. The scope of the project is quite broad with the basic intent to maximize services by coordinating local resources. To develop the concept further, however, we must:

(1) promote such linkages through existing federally-funded programs. For example, legislation which encourages community health centers and local public health departments to work cooperatively with rural hospitals should be considered. (2) encourage our nation's medical schools—especially those with a community-based focus—to become more involved in working with rural communities. The Alabama project serves as a potential model.

- encouraging integration of services at the local community level.

There are several efforts in the Upper Midwest to promote the development of integrated services in rural areas. One such example is West River Health Services in Hettinger, North Dakota. Hettinger is a frontier community of 1,400 with 18 physicians providing services over an area of 30,000 square miles. To enhance the survival of the rural health system—which is considered one of the most innovative in the nation—West River is exploring the notion of merging all local health services under one system. They would collapse the local hospital, nursing home, public health programs, outreach nursing services and the physician's clinic into one unified structure. Their intent is to sustain the whole system by bringing it together. Legal counsel is concerned that the development of such a system would trigger Federal Trade Commission concern. We must:

(1) once again, foster the development of such systems by placing an emphasis on such approaches through support of the reimbursement system.

(2) reducing any legal barriers for such approaches to sustaining services especially in the most rural areas of the nation.

While not every rural hospital needs to act on all of these options, most should at least be considering them. It is ironic that the hospitals with the most need for change are often the ones with the least human and financial resources with which to accomplish the task. When General Motors or the Chrysler Corporation decides to make different cars they retrofit their factories. The retrofit requires an investment in physical and human capital. We are discussing a "retrofit" for rural hospitals without any investment in physical or human capital. The only program currently supporting such a retrofit is the Transition Grant program—and it is vastly over-subscribed. I would strongly encourage the Members to examine how best to facilitate support for the rural hospitals who are willing to experiment, to develop new services, to downsize—but who need the requisite resources to accomplish the task.

In sum, I strongly support the efforts of the Committee to develop legislation addressing the specific needs of rural hospitals. These facilities represent the cornerstone of the rural health care delivery system. Rural hospitals are vulnerable to a variety of forces beyond their control. You can help us help them by passing legislation that will bring equity to our reimbursement system for rural hospitals. You can provide the resources for assistance in the retrofit of these institutions for a new and important role in the rural health system. You can provide them with the incentives for exploring new and different approaches for delivering services in rural areas. Thank you again for the opportunity to share these thoughts and recommendations with the Committee.

RESPONSES TO QUESTIONS SUBMITTED BY SENATOR PRYOR

Question. Is there a disproportionate burden of proof for rural America and the rural hospitals vis-a-vis urban America and the urban hospitals in proving a difference in cost? The burden of proof issue is one that I think needs to be addressed.

Answer. The major problem with the whole debate on Medicare reimbursement stems from an assumption that was made back in 1983. The assumption made at. that time was that eggs were cheaper in the country. There was no debate, no discussion, no consideration of the issue—it was simply accepted to be fact. As a result, the rural hospitals over the last seven years have had to fight a rear guard action of pleading their case that in many instances there are *no* differences in costs *and,* in some cases, costs are actually higher. The other issue that too often confuses the situation is comparing the per unit costs of rural hospitals to urban hospitals. In cutting costs, hospitals across the country have done an admirable job of reducing costs to a bare minimum in most cases. The problem comes when as an administrator you get down to basic levels such as having one or two laboratory technicians in the lab. To provide quality health care, the hospital needs to maintain a minimum floor of services even if fewer patients are seen in the facility. This situation results in a higher per unit cost for a particular facility even though aggregate costs of the facility are considerably less than urban facilities.

Question. Is 1994 a proper time, is it an adequate time, for us to phase in this legislation that we are considering at this time, or is it too late, or what is going to happen in the meantime? that is to address the 1994 issue.

Answer. I believe that 1994 will be too late for many of our rural hospitals throughout the nation. I hasten to add that it is not a simple question of hospital closure but access to basic health care services by the rural elderly. The major problem with the directions we are now taking is that our health care system will haphazard closure of facilities rather than reasoned, planned closure or downsizing. As an example, the eastern half of Arkansas which is relatively more impoverished than the western half could experience considerably more closure of facilties because of insufficient resources. The same type of problem will be experienced throughout Appalachia, the frontier regions of the Western States and in the impoverished areas of the rural Northeast. We cannot afford to wait. Action is required now.

Question. If we do nothing, if we absolutely do nothing about this formula, where will we be in rural health care in the United States say in the next five years?

Answer. I have advocated for many years that the rural health care system is dependent upon the viability of the rural hospital. If no rural hospital is present, the ability to recruit physicians to a community is near impossible; the ability to provide adequate ancillary services is dimminished; the ability to maintain a preventive focus within our public health services difficult; and, the ability to sustain the economic viability of our rural areas jeopardized. I believe the rural health question is inextricably tied to the question of rural America's viability. If we want a strong rural America certian basic services are required: good roads, telecommunications, quality water, basic fire and police services; and, access to basic health care. The decision is a fundamental one—Do we believe there is a need for a strong rural America? Is it in our national interests? Are there reasons for keeping the breadbasket of the world alive and viable. I happen to believe there are many strong reasons for fashioning a policy which supports the enhancement of rural America. Without it, I believe our nation is at risk.

PREPARED STATEMENT OF SENATOR ALBERT GORE

Mr. Chairman, thank you for the opportunity to testify this morning about the steadily deteriorating condition of our nation's rural hospitals. I know we agree on the extent of the problem, and on the need to act promptly. In fact, I am pleased to have joined you as a co-sponsor in introducing the "Equity for Rural Hospitals Act" in January, and delighted to see that more than half the Senate has also become cosponsors of this important step for rural hospitals.

The overwhelming support S. 306 has received, and the large number of good bills addressing this issue are important signs of hope for the millions of Americans who count on these institutions. Time is short for many rural hospitals, but I am confident that now that a majority of us agree that there is indeed a serious problem, we will be able to act quickly to put rural hospitals on the road to recovery.

No American should have to worry about access to appropriate, affordable health care. Yet rural citizens are the latest in a growing list of groups who can no longer count on access to health care.

Earlier this year, as I travelled across Tennessee from one town meeting to another, I was deeply troubled to hear over and over again pleas for help from people who are worried about keeping their local hospitals open and ensuring access to appropriate care in their communities.

The State government classifies 45 of Tennessee's 95 counties as medically underserved. Thirteen of these have no hospital at all. There are 31 counties with only one hospital which serves as the sole community provider of inpatient care in the county.

Each year the list grows longer. Many of these hospitals are in financial jeopardy—most through no fault of their own. They are threatened by a Federal system that discriminates against them, forcing rural hospitals to do more with less.

The "Equity for Rural Hospitals Act" would solve many of their problems. I have discussed the bill with hospital administrators across my State. They support it and offer only a few suggestions. They hope that Section 3 could be modified to include hospitals in which Medicare accounts for at least 55 percent of payments, rather than 70 percent. And they would like to see Section 2 allow sole community providers to cover their actual costs until 1995, when rural payment rates would catch up to urban rates.

There are many pressing issues we must deal with this year. But frankly, it is time we stop looking at access to health care as simply one of a list of important issues competing for a limited pool of funds.

A recent Roper poll illustrates my point. Asked whether health care was a right or a privilege, 71 percent of Americans said it should be a right. Only 50 percent said the same of an adequate standard of living, 34 percent for basic telephone service, and 30 percent for a college education.

Failing rural hospitals are another sign that even though we spend half a trillion dollars a year on health care, American citizens are losing ground. It is time for America to provide the world's best health care system, not simply the most expensive.

This is a battle we cannot afford to lose. I urge the committee to report out a rural hospital bill.

Thank you Mr. Chairman, and thank you for your personal leadership.

PREPARED STATEMENT OF SENATOR TOM HARKIN

Thank you, Mr. Chairman and members of the Committee, for allowing me to appear before you this morning. I am here on behalf of the Senate Rural Health

Caucus and its 67 members. I am honored to serve with you and many members of your Committee on the Senate Rural Health Caucus.

Mr. Chairman, just a few facts about rural health. Rural Americans account for a quarter of our population, almost a third of the elderly, and over half the poor. Across the country, rural areas show higher rates of maternal and infant mortality, chronic illness and disability, and higher morbidity related to diabetes, cancer, high blood pressure, heart disease, stroke, and lung disease than urban areas.

The rate of uninsured rural Americans is 15 percent higher than the U.S. Average and a full 24 percent above urban levels. Yet only one-fourth of the rural poor qualify for Medicaid, compared to 43 percent of the poor in inner cities. The costs of indigent care place a growing financial burden on rural hospitals.

Many rural occupations are hazardous: farming, mining, and timber are among the most dangerous in the nation. There is a critical need for comprehensive emergency medical systems, and accessible hospital care. The rural elderly pay the same Medicare premiums as senior citizens living in cities—don't they deserve the same access to quality health care?

But there is no guarantee of access to hospital care in rural America today. Since 1980, 206 rural community hospitals have closed—two in my home State—and another 500 rural hospitals are in serious financial trouble. The situation is getting worse every day.

I believe a major cause of the problems facing rural hospitals today is Medicare's Prospective Payment System. The system is based on theory, on the law of large numbers. for hospitals that serve large numbers of patients, the system has, for the most part, worked. But for hospitals without the benefit of great numbers of patients, PPS has ment a slow starvation.

Mr. Chairman, I argue that PPS is biased against rural hospitals. Just a quick look at the balance sheet makes my case: Urban hospitals account for about half of PPS hospitals, but receive 83% of Medicare payments. Their payments average 40% more for each case. In addition, urban hospitals get 96% of added payments for teaching, 96% of disproportionate share payments, and 92% of outlier payments. In my home State of Iowa, the bill for inpatient hospital care in 1987 came to over $1.1 billion. Of that amount, 34 hospitals in urban communities received 86% ($950 million), while Iowa's 93 rural hospitals received only 14% ($159 million).

Mr. Chairman, the inequity is undeniable. As a result of inequitable Medicare payments, more rural hospitals are closing than ever before and access to care threatened. The "special" designation of Sole Community Hospital that is meant to protect isolated rural hospitals has turned out to be an albatross. These hospitals have fared the worst of all under PPS.

Mr. Chairman, the budget now under consideration makes us all sensitive to the need to control soaring Medicare costs, and protect beneficiaries from higher deductibles. It seems to me that if we want to control hospital costs, we need to concentrate on the group of hospitals that are getting 83% of the payments, and not on the group that's only getting 17%.

PPS has been in place since 1983. We have examined it and adjusted it, studied and studied and studied. And still what we have is a "separate but equal" system of payments to urban and rural hospitals. It's not working.

Mr. Chairman, the time has come for a change—a comprehensive change—in Medicare payments to rural hospitals. I am cosponsoring your bill to eliminate the urban-rural differential, and support financially distressed rural hospitals. This legislation takes a balanced, thoughtful approach to reforming Medicare hospital payments over the next few years.

Unfortunately, many rural hospitals can't wait that long. I hope you will be able to eliminate the urban-rural differential this year, and am introducing a resolution calling for this action.

I would also urge you to consider lowering the threshold for "financially distressed" rural hospitals to qualify for protection payments. I am afraid the 70% threshold will not protect many rural hospitals that are critical to preserving access to care.

In this regard, one concept I support is an access index for hospitals that are necessary to providing access to care. Like the payments made to urban hospitals for teaching, disproportionate share, and so on, an access index would recognize hospitals that are vital to maintaining services to remote areas or special populations.

Mr. Chairman, we need to reinvest in rural hospitals and our rural health system. It's the backbone of many rural communities, and essential to maintaining the quality of life so many Americans take for granted.

Rural hospitals practice a more "conservative" style of medicine; they furnish less resource-intensive, and therefore less costly, care than urban hospitals. It's the same high quality care, it just costs less. I believe we ought to reward that prudence, not punish it with low payments.

If we don't act quickly to change Medicare's Prospective Payment System, the health care system in rural America will crumble. If that happens, we will be forced not very long from now to take drastic measures—with a drastic price tag—to rebuild it. That would be a grave mistake. On behalf of the Senate Rural Health Caucus, I urge you and the Committee to take action now on behalf of rural hospitals and rural communities.

Thank you.

PREPARED STATEMENT OF ROBERT L. HARMAN

Mr. Chairman and members of the Committee, I am Robert L. Harman, Administrator of Grant Memorial Hospital, Petersburg, West Virginia, a position which I have held since 1965. This facility is a county-owned hospital licensed for 96 beds, but is currently operating 59 beds. In addition, I am Chairman of the West Virginia Hospital Association's Small and/or Rural Hospital Committee, and Chairman of the American Hospital Association's Governing Council for Small or Rural Hospitals. The Governing Council represents approximately 1700 hospitals nationwide.

I appreciate the opportunity to testify before you today to discuss some of the problems impacting hospitals nationally, but more specifically to speak to problems affecting small and rural hospitals. Hospitals in my own State suffer from the same set of problems that affect hospitals throughout the country. Currently there are 62 hospitals in West Virginia of which 30 are small and rural. Since December 1987, five small and rural hospitals have closed in West Virginia including Holden Hospital in Holden, Steven's Clinic Hospital in Welch, Tucker County Hospital in Parsons, Wyoming General Hospital in Mullens and E. C. Leonard Memorial Hospital in Buckhannon. In three of these closures, the hospital was the only general acute care hospital in the county. An additional five or six hospitals within the State of West Virginia are experiencing serious financial difficulty and there is great concern for their continued viability. Nationally, we have seen a significant number of rural hospitals close within the last 8 years. Reliable statistics show that approximately 163 rural hospitals have closed. Over forty of these have closed in the last year alone.

There is now a general agreement that Medicare's Prospective Payment System does indeed discriminate against rural hospitals and consequently against the elderly living in rural areas. Several aspects of the Prospective Payment System lead us to make this Statement, and I will touch upon at least two of them. We believe that Medicare's urban/rural differential which is a major component of the Prospective Payment System is one of the major reasons why rural hospitals are experiencing severe financial difficulty and are indeed beginning to close their doors in greater numbers. When the wage index is included with the urban/rural DRG differential, rural hospitals receive approximately 35% less per DRG than urban hospitals receive.

Using data from the American Hospital Association's 1987 survey of hospitals and from the West Virginia Health Care Cost Review Authority, we see that in 1987 West Virginia had 35 small and rural hospitals. In this time frame, 22 of these 35 hospitals had lost money from operations averaging a loss of $404,000 per hospital. The West Virginia Health Care Cost Review Authority has also recently released a study of Medicare operating margins for 1987. While they do not have complete information on all 35 small and rural hospitals which were referred to previously, they do have data from 31 of these hospitals. Of the 31 small and rural hospitals, 20 had negative Medicare margins with a total Medicare loss of $7,439,629 which averages roughly $371,000 per hospital. The data clearly shows that if Medicare was reimbursing hospitals at an equitable rate, most hospitals currently losing money in West Virginia would at least be breaking even. This data is illustrated in the table attached to this testimony. Also attached is a table of operating margins for 1983 and 1987.

The PPS-DRG System was initially established to cover a reasonable amount of the cost of providing care to the Medicare population. The fact is, it does not. The DRG System of payment works only when patients do not remain hospitalized for very long and do not receive an inordinate amount of hospital services. The reality is that people over 65 years of age have more health problems, become hospitalized more frequently, are sicker and require a greater intensity of hospital services. The concept of averages does not work in small and rural hospitals. The Medicare System also has a provision for an add-on to the DRG reimbursement for hospitals which provide a disproportionate share of services to low income patients. A formula has been established to arrive at the add-on payment also determined on an urban/rural basis. Again, the reimbursement to rural hospitals is quite different from that of urban hospitals. An urban hospital has to provide less indigent care to get a higher add-on payment than a rural hospital. Rural hospitals are required to provide more indigent care in order to get a lesser percentage of add-on reimbursement under the Medicare Program. This illustrates another aspect of the Medicare program that discriminates against the rural facility.

We know that a one year operating loss does not necessarily create a financial crisis; however, West Virginia's small and rural hospitals have experienced continual operating losses since 1984, the first full year of the prospective payment system. West Virginia hospitals' financial crisis is more fully explained in a study recently completed by the West Virginia Hospital Association. I will provide you a copy of this document for the record.

In other testimony before the Congress, it has been projected that payments by Medicare to the average hospital will fall short of cost by between 8 and 9% and also that nearly ⅔ of all hospitals will lose money caring for the Medicare patient. Half of these hospitals will incur deficits of 10% or more and nearly 30% will incur losses of 20% or more. These projections are the same regardless of location or class of hospital.

The argument is made that hospitals nationally and particularly small rural hospitals may indeed be losing money, but that Medicare's reimbursement policies are not the reason. Obviously there are other reasons such as declining local economies, an increasing indigent care burden, inadequate Medicaid reimbursement, and the increasing cost of new technology. As Stated previously, the urban/rural differential is a leading factor and while it cannot be singled out as the sole cause for rural hospital closure, it is difficult to see any improvement in the financial condition of rural hospitals without the provision of an *equitable* and *adequate* Medicare payment policy. The elimination of the urban/rural differential is a necessary step in ensuring equitable and adequate payment for all hospitals, *not* on the basis of geographic location but on the basis of labor and other resource costs in the treatment of patients.

The threat of closure is a daily experience for a large number of hospitals nationally. The Firm of Touche Ross indicated in a study performed in West Virginia in 1987 that 50% of the 30 small and rural hospitals responding felt that they were at risk for closing within the next five years. The four most prevalent reasons for this feeling of risk were: cutbacks in Federal funding, Federal and State regulations, escalating operating costs and increasing indigent care. Indigent care is a major concern for small and rural hospitals nationally and especially in West Virginia. There is also a rapidly augmenting concern about the ability to access needed health care services in rural areas should the trend to closure continue. Rural hospitals play a crucial role in the personal well-being of rural Americans from the provision of Emergency Medical Services to Health Education. From newborn obstetrical care to long term care services, the rural health care delivery system is meeting a demonstrated need. The specter of closure, however, places access to care in jeopardy.

As the demand for services increases and it surely will in the coming years, and as the pressure to reduce reimbursement levels grows, the ability to access health care services will become more acute. Problems in accessing care will be a natural result of this process. An immediate example of this can be seen at Grant Memorial Hospital. Our hospital serves a three county area for medical-surgical services. However in obstetrical care, our service area encompasses five counties. We are the only facility in the five counties providing obstetrical care and have the only physician in five counties providing this service. This service area stretches for 70 miles north and south and 70 miles east and west. Because of recent problems in Medicaid reimbursement in West Virginia, physicians in neighboring States decline to accept Medicaid obstetrical patients. Consequently, our facility is the only hospital providing this service to these patients in this area. The nearest hospitals to us that provide Obstetrical care are in Maryland (60 miles) and Virginia (75 miles). Were we to find ourselves in a situation requiring closure, this would create an extreme access problem for these patients in this large geographic area.

I am not foolish enough to believe that Grant Memorial Hospital is an isolated situation. I firmly believe that examples similar to this can be found throughout the country and in all aspects of care, not just obstetrics. To whom does the patient turn when the local provider of care is no longer in existence? Are we approaching the acceptance of solutions such as those currently being debated in the Oregon Legislature of a priority system for providing health care services to Medicaid patients?

Although we do not like to say it, this is a form of rationing care to the less affluent members of our society.

Hospitals and particularly rural hospitals are also facing a crucial shortage of professional and technical hospital personnel. As a result, hospitals must provide more rapidly increasing wage and benefit increases to entice these individuals into rural hospitals. This critical problem with its drastic financial solution is not recognized in the wage index. The wage index, as you are well aware, plays a major role in determining reimbursement for rural institutions.

Rural hospitals have taken a very active role in trying to adjust to and accommodate for the new environment in which they find themselves. They have explored many new avenues for service. They are diversifying their services and developing an attitude of being a rural health center rather than merely an inpatient facility. They are becoming more involved in integrating and coordinating health care services in their service area. At Grant Memorial Hospital, we have selected various diversification opportunities to better serve our community in today's environment. These include family centered maternity care, skilled care, swing beds, respite care, home health care, homemaker services, hospice care, outpatient surgery and outpatient orthopedic and podiatry clinics. Other facilities have substance abuse programs, wellness programs, retirement community housing, women s medicine programs, durable medical equipment and health education. Diversification is a viable option for many facilities. Each facility and the community that it serves must determine the services that it needs and those which can be provided through the local provider. Experience has taught us that the hospital can be a key player in coordinating many of these community oriented services and in the process maintain its viability. Attached to this testimony is a table illustrating the various diversification strategies and the success rate associated with each service.

In view of the preceding, rural hospitals face the increasingly difficult task of being able to continue to provide needed health care services in an atmosphere of decreasing reimbursement levels, increasing costs of resources and capital and the ever mounting expectations of the patients that they serve. The ability of these institutions to complete this evolutionary process depends in great part on community acceptance and legislative support. In this light, I would encourage your continued support for the Rural Health Transition Grant Program. This Program can provide additional opportunities for rural facilities to demonstrate innovative approaches in the provision of health care services.

In summary, Mr. Chairman, I believe that Medicare has continued to assume a disproportionate share of the Federal budget cuts since the inception of the PPS in 1984. Those cuts have had serious impact on the financial stability of West Virginia's rural acute care hospitals which are entering 1989 in the most precarious financial position in their collective history. The cuts have had an equally devastating effect on rural hospitals at the national level. Legislative support can make a difference Your support for the elimination of the urban/rural differential, adequate funding of the Medicare Program, continued funding and support for the Rural Health Transition Grant Program, elimination of barriers to diversification and support for ensuring access to care is a vital step toward bringing stability to the rural health care delivery system. Failure to remedy the rural equity issues and the overall adequacy issue will almost certainly result in the closure of additional hospitals nationally and very assuredly in West Virginia. Closures and the resultant problems of access to care are real issues today in rural America.

I do sincerely appreciate the opportunity to be with you today and look forward to working with you in ensuring the viability of the rural health care delivery system.
Enclosures.

SMALL RURAL HOSPITALS—1987 MEDICARE PROFITS/LOSSES

Hospitals	Excess Revenue Over Expenses Total	Excess Revenue Over Expenses Medicare
Boone Memorial Hospital	($160,403)	($160,334)
Braxton County Memorial Hospital	(186,668)	(360,478)
Broaddus Hospital	(368,106)	(333,657)
Calhoun General Hospital	46,314	N/A
E. C. Leonard Memorial Hospital	(125,958)	(71,583)
Grafton City Hospital	(473,366)	(425,204)
Grant Memorial Hospital	227,556	(34,311)

SMALL RURAL HOSPITALS—1987 MEDICARE PROFITS/LOSSES—Continued

Hospitals	Excess Revenue Over Expenses Total	Excess Revenue Over Expenses Medicare
Greenbrier Valley Hospital	546,409	1,142,246
Guyan Valley Hospital	59,779	68,907
Hampshire Memorial Hospital	(136,007)	33,484
Holden Hospital	40,866	(84,428)
Jackson General Hospital	123,947	(182,363)
Jefferson Memorial Hospital	(53,936)	N/A
Man Appalachian Regional Hospital	(512,888)	(159,454)
Montgomery General Hospital	(875,793)	(2,620,874)
Morgan County War Memorial	(79,585)	(16,450)
Plateau Medical Center	1,143,122	787,973
Pleasant Valley Hospital	364,535	(918,955)
Pocahontas Memorial Hospital	(84,533)	45,464
Potomac Valley Hospital	170,894	169,476
Preston Memorial Hospital	(729,968)	(614,977)
Putnam General Hospital	(966,753)	850,626
Roane General Hospital	(568,555)	(568,020)
Sacred Heart Hospital	(836,440)	(363,205)
Sistersville General Hospital	(122,600)	(8,186)
Stevens Clinic Hospital	163,415	1,045
Stonewall Jackson Memorial Hospital	115,250	(29,119)
St. Joseph's Hospital-Buckhannon	716,669	80,045
Summers County Hospital	(53,343)	83,874
Summersville Memorial Hospital	352,102	(162,084)
Tucker County Hospital	(177,712)	(83,161)
Webster County Memorial Hospital	196,107	N/A
Wetzel County Hospital	76,261	(242,786)
Williamson Memorial Hospital	468,180	931,438
Totals	(1,889,713)	(3,245,051)
Total Medicare Losses from Hospitals with Negative Medicare Margins	(7,439,629)	
Total Losses from Hospitals with Overall Negative Margins	(6,556,825)	

DATA SOURCE: West Virginia Health Care Cost Review Authority.

DIVERSIFICATION STRATEGIES—RANKED BY SUCCESS IN GENERATING A PROFIT OR BREAKING EVEN

[In Percent]

Service	Success Rate [Percent]
Outpatient Surgery (Freestanding onsite)	96.1
Outpatient diagnostic (Freestanding onsite)	88.8
Cardiac Rehabilitation	83.4
Substance Abuse	82.6
Inpatient Rehabilitation	81.7
Outpatient Surgery (Satellite)	81.2
Industrial Medicine	80.9
Sports Medicine	80.0
Home Health	78.7
Women's Medicine	76.4
Preferred Provider Arrangement	74.6
Extended Care	73.0
Outpatient Diagnostic (Satellite)	71.9
Retirement Community Housing	70.3
Psychiatric Treatment (Outpatient)	70.2
Emergency/Trauma (Satellite)	60.9
HMO	59.4
Wellness/Health Promotion	49.0

SOURCE: Hamilton/KSA, 1987; as cited in "Diversification: More Black Than Red Ink," ***Hospitals***, 62(1):36–42.

Operating Margin

1983-1987

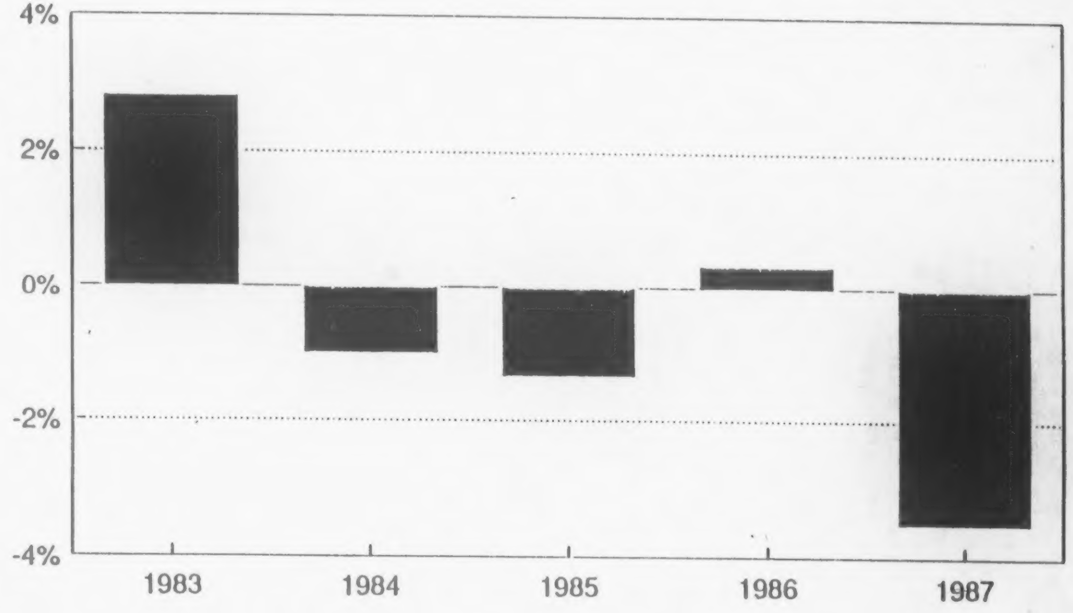


Figure 6

PREPARED STATEMENT OF SENATOR JOHN HEINZ

Mr. Chairman, for one in four Americans, the rural hospital is the primary source of health care for everything from tonsillectomies to heart surgery. It is therefore of great concern to the members of this Committee—who represent so many of these Americans—that growing numbers of these hospitals are having to limit the services they offer or, in the worst case, close down completely under financial pressure.

Simple demographic shifts from rural to urban centers have contributed to falling hospital occupancy rates and shrinking private revenues. The high cost of medical technology has making it harder for rural hospitals to compete with urban counterparts. Faced with a shortage of nurses and other health care personnel, hospitals have had to divert more revenues to salaries and benefits in order to compete for essential staff.

Unfortunately, there is little the Government can do to counter many of these forces. But there is one force that the Congress can can do something about—Medicare's failure to adequately reimburse rural hospitals. What we are here to learn today is the extent to which Medicare reimbursement is undermining efforts to deliver medical services to rural America and what corrective actions should be taken.

Congress never intended Medicare's prospective payment system (PPS) to become a chopping block for rural hospitals. Yet, there is no doubt that rural hospitals have suffered disproportionately. Since 1984, the first year of PPS, the average profit margin of rural hospitals dropped from 8 percent to a *negative* 6 percent. The drop for urban hospitals, while still significant, has been from 15.5 to 5.6 percent. Since 1984, 159 rural hospitals have also closed—including two in my own State. Another 600 rural hospitals may close within 5 years.

As the Congress became aware of problems in Medicare's treatment of rural hospitals, we took steps to increase their annual payments and to grant certain rural hospitals Medicare's urban rate. It now appears that we were applying bandaides when we needed a cure. At the heart of the cure is the elimination of different rates for urban and rural hospitals. I am therefore pleased, Mr. Chairman, to be an original cosponsor of your bill that phases out this differential. Your bill also provides vital relief to rural hospitals that have been especially hard hit under PPS. And, it creates interim review boards to consider the appeals of hospitals who receive their reimbursement at a rural address but must compete with other hospitals on urban footing.

I look forward to learning the views of our witness today on what changes are needed in Medicare's approach to reimbursement and in our approach to providing care to rural communities. To the extent that Medicare is part of the problem, it must be part of the solution.

PREPARED STATEMENT OF SENATOR JOHN MCCAIN

Mr. Chairman, I welcome this opportunity to submit a Statement for the record relating to the critical issue of Medicare reimbursement to rural hospitals. Representing the people of Arizona, I am particularly concerned about the adequacy of Medicare payment levels to Medicare-dependent hospitals, including those located in rural communities. Senator Bentsen, the distinguished Chairman of the Finance Committee, and Senator Dole, the distinguished Republican Leader, have properly focused on the plight of rural, Medicare-dependent hospitals by including a provision specifically aimed at these facilities in S. 306, the "Equity for Rural Hospitals Act of 1989."

Available Medicare data indicate that Medicare-dependent rural hospitals have Medicare operating margins considerably lower than other hospitals. However, these data also show that urban Medicare-dependent hospitals are also disadvantaged under Medicare's hospital prospective payment system (PPS) compared to facilities with a smaller proportion of Medicare inpatients. For example, projections for fiscal year 1987, developed by the Consolidated Consulting Group, show the following average Medicare operating margins:

—0.7 percent for all hospitals with 65 percent or more Medicare days compared to 7.2 percent for all hospitals;

—4.4 percent for rural hospitals with 65 percent or more Medicare days compared to 0.4 percent for all rural hospitals; and

—0.0 percent for urban hospitals with 65 percent or more Medicare days compared to 8.2 percent for all urban hospitals.

Thus, both rural and urban Medicare-dependent hospitals are doing more poorly than non-Medicare-dependent institutions have almost no ability to make up for in-adequately reimbursed Medicare costs from other payors. Obviously, it would be unreasonable for us to expect a Medicare-dependent hospital to remain viable if it simply tried to pass along its Medicare losses to private insurers, employers and others responsible for paying for the care of its relatively small non-Medicare patient population. Thus, I believe that S. 306 offers us an appropriate vehicle for addressing the problems of all Medicare-dependent hospitals, not just those located in rural communities.

In our consideration of the concerns of Medicare-dependent hospitals, we should also address capital payment issues. At this time, a 15 percent reduction in payments for Medicare capital costs is applied to all hospitals, including Medicare-dependent hospitals. The administration has proposed imposing a 25 percent reduction in these payments for fiscal year 1990. While S. 306 would provide special consideration for the operating costs of rural, Medicare-dependent hospitals, it does not address the capital costs of these facilities. I strongly urge the Committee to look at this issue in conjunction with consideration of the bill.

Medicare-dependent hospitals—both urban and rural—are particularly vulnerable to Medicare's unwillingness to pay its full share of capital costs. In addition, a number of these hospitals are located in communities whose Medicare population is growing—e.g. sunbelt communities—and thus greater demands are being placed on them. Thus, while reductions in payment for Medicare capital costs are problematic for all hospitals, Medicare-dependent hospitals find it particularly difficult to meet the needs of the Medicare population in their communities.

I would also like to suggest that the Committee give further consideration to the criteria under which a hospital would qualify as Medicare-dependent. S. 306 defines a Medicare-dependent facility as one for which "at least 70 percent of inpatient hospital services (determined, at the hospital's option, on a per diem basis or on a discharge basis) are attributable to inpatients who are entitled to benefits under Part A."

However, I beleive that qualifying criteria should be based on the proportion of Medicare days rather than services. Congress chose a day-based standard for disproportionate share hospitals and this type of standard appears to be easy to understand and administer. Secondly, I urge the Committee to consider lower the Medicare utilization standard from 70 percent to 65 percent, since available Medicare data suggest that hospitals with 65 percent or more Medicare days have Medicare operating margins significantly lower than hospitals with a lesser proportion of Medicare inpatients. There are approximately 380 such hospitals, about 70 percent of which are located in rural areas. Thirdly, as noted above, I believe that both urban and rural facilities should be able to qualify for special consideration as Medicare-dependent hospitals. Therefore, I believe S. 306 should be amended so that such relief is not limited only to rural, Medicare-dependent hospitals with 100 or fewer beds.

Finally, the appropriate mechanism for providing special recognition of the capital and operating costs of Medicare-dependent hospitals needs careful consideration. S. 306 provides a payment "floor" that would cover the reasonable operating costs of Medicre inpatient care. The Association of High Medicare Hospitals, an organization representing Medicare-dependent hospitals, has recommended a per case payment adjustment for operating costs and full payment of capital costs. Whatever the form of the relief, we will need to assure ourselves that all hospitals concentrating in the care of Medicare beneficiaries will be able to continue to serve their communities. I am pleased to say that I am a cosponsor of S. 306, and look forward to working with the Committee as it addresses the concerns of Medicare-dependent hospitals.

PREPARED STATEMENT OF MIKE D. McKINNEY

Chairman Bentsen and members, thank you for this opportunity to discuss rural America's lifeline to health care.

My name is Mike McKinney. I'm a physician in family practice, and my home is Centerville, Texas, about 120 miles northwest of Houston. With me today is Mr. Tom Nance, Administrator of Atlanta Memorial Hospital, 25 miles out of Texarkana, to assist with questions about the financial impact of Federal decisions on rural health care.

I wish I could have brought my own administrator, from Leon Memorial Hospital in Leon County. But he's out looking for work, because Leon Memorial closed three weeks ago.

Ordinarily, when the Texas Legislature adjourns at the end of May, I'd go back to Centerville to resume my practice. But this year there's no hospital in Centerville to admit my patients.

My facility is gone. My ability to deliver quality acute care has been compromised, if not destroyed, and my patients are the ones who will suffer. I'm young, I'm professionally trained. After years of intensive peer review, my record of patient care is spotless.

But when the hospital goes, the doctor goes. I can relocate, but if I do, I'll leave behind a community that is older, poorer, and sicker than people in the cities. When the hospital goes, the doctor moves. When the health care has gone, the community has no future; the young people move away, along with their jobs.

Nothing remains but the old folks, who wonder what happened to their families, to their town, to the health care they bought and paid for in Medicare.

Sadly enough, there's nothing unique about the fate of Leon Memorial. For three years in a row, Texas has led the nation in hospital closures. We've lost fifty-two rural hospitals since 1984. Combined with fifty other counties that had no hospital to begin with, the rural safety net has more holes than string.

Did they close because they were inefficient? Badly run? Too costly? Clearly this is not the case. The American Hospital Association's 1987 State-by-State comparison shows that Texas hospitals outperform the national average in length of stay, cost of stay, beds per capita, admissions per capita, and per capita hospital costs.

They closed because well-intentioned policy has produced results that none of us intended. I'm here today to describe what we've learned about our rural hospitals, and how you can grant the relief we need to preserve rural America's access to care.

In 1987, the Texas Legislature created the Special Task Force on Rural Health Care Delivery. I served on the Task Force, and I want to briefly summarize its findings, the actions we have already taken to shore up the system, and what we ask of Congress.

The rural population of Texas is larger than the total population of 23 sister States. 3.2 million Texans live in non-metropolitan counties, where the poverty rate is almost seventy per cent higher than the cities and the over-65 population is sixty per cent larger. Those are big numbers, but the truth is that we're like everybody else-only more so. Your own States will experience our problems in proportion to your rural populations.

Aging and poverty yields a high percentage of Medicare patients in our rural hospitals. Attached to my testimony are data runs generated by the Texas Hospital Association's Datapulse Program, showing that as of this week, seventy-six of the 155 rural hospitals in our State bill forty per cent or more of their patient days to Medicare. My second attachment shows that every year since the Prospective Payment System was implemented in 1984, rural hospital margins have narrowed and then gone into the red. Under current law, 1990 losses would rise to 10.49 per cent, or 13.54% if Congress accepts cuts proposed by the budget negotiators.

Thus we can truly be said to be dependent on your Medicare decisions for our day-today solvency. I will go so far as to say that two bad months in any of our small-town hospitals will shut it down. It could happen even faster: if HCFA refused to reimburse for even one catastrophic Medicare case, a hospital without reserves could close for the sake of a single patient.

These hospitals and their physicians cannot continue to operate under an urban/rural differential that pays us thirty to forty per cent less than our peers in the city. Before Leon Memorial closed, we earned $1,520 for pneumonia case. Hermann Hospital in Houston got $2,900 for the same patient. Unlike the payment system, disease does not discriminate.

My older patients can't afford to travel to Houston, even if they can drive. I charge $22 for an office visit, but Medicare pays me only 16.60. I eat that loss of $5.40 per elderly patient because I will not force them from their homes.

Medicare reimburses only for the admitting diagnosis. What happens if despite my best work, a sicker, poorer Medicare patient encounters complications? My hospital absorbed that extra cost, until it closed.

We tried to cut costs by cutting staff, so our clerical staff was overloaded. Any mistake they made on triplicate Medicare forms resulted in denial of payment.

We complied with HCFA's medical staffing requirements, even on days when our census was too low to cover the costs. We maintained a registered nurse 24 hours a day; we found certified lab techs and X-ray technicians who would live in a small town and remain on-call around the clock. Right now those good people are also looking for work.

I mentioned that I have fared well under peer review, and I hope it wasn't luck. But the Texas peer review contractor looks at a minimum of 3% of a hospital's charts each year. If there's a problem, they can call in every chart a doctor signs. In my hospital, I was on the line for virtually every decision. Some doctors resent that kind of oversight, and they move to a large urban facility, where the odds are much lower that they'll be called on the carpet.

Finally, some specialties are simply disappearing. 92 of our counties have no obstetrical services; a survey by the Texas Medical Association shows that 61% of our family practitioners will no longer deliver babies, and almost half of our OB/GYNS have curtailed high-risk deliveries. Much of this provider loss is attributable to litigation, not Medicare. But an OB/GYN needs an acute care facility to practice in, so another hospital closed by reimbursement policies means another county without obstetrical services.

Those are the kinds of problems we face because of the discriminatory design of the Medicare reimbursement system. But I want you to know that we've fought back with every tool at our disposal.

Across the State of Texas, we've cut costs, cut staff. We've stalled construction and procurement. We've gone to generic drugs and reduced our formularies.

We're passing legislation this month to provide regulatory relief, consolidate paperwork, promote regional resource networks. We're changing jury instructions on emergency treatment and bad results, and changing the treatment of expert witnesses to address our liability problems.

We're expanding our Medicaid program, raising eligibility, increasing our standard dollar amount. We're spending unmatched State dollars on grants to shore up the rural primary care network, to keep hospital admissions and costs as low as possible.

It may take another Session, but we hope to clean up hospital licensure to permit more diversified bed usage for drug abuse, MH/MR patients, and respite care for the elderly. And we're about to ask Congress to reconsider the Medicaid requirement that every disproportionate share hospital must maintain 24-hour obstetrical services, so more rural hospitals can tap into Disproportionate Share payments.

We've fought for survival, and we won't surrender. But all our work is meaningless without relief from a Medicare reimbursement system that's designed to relocate our beds to the cities while the patients stay behind.

We beg for relief. We support efforts by the congressional Rural Health Care Caucus to shore up rural medical education, to expand and continue Transition Grants. We request that you re-evaluate some especially onerous requirements in the Medicare Conditions of Participation that permit no flexibility in considering our special status and needs. As we work to pass our own trauma legislation, we ask you to proceed with yours and to incorporate funding for transition, for improved communications, emergency services and transportation.

But above all, we beg you to restore payment equity between urban and rural hospitals. Our patients are older, sicker, and poorer. Ours is the greater burden, and the lesser portion of what we have guaranteed to the elderly American.

I'm a country boy, a conservative Democrat. I'm a legislator from a balanced budget State, and I've never voted for a deficit. I know what it means to ask you for money when you're fighting a desperate battle against the Federal deficit.

But I'm also a doctor. I just lost my hospital. From the bottom of my heart, I promise you that there are thousands like me and thousands yet to come. Think of the patients. Think of the small towns, and the people who pass by them on the highway. Before there is no care in the countryside, please act.

Thank you.

02-May-89

Attachment 1

TEXAS HOSPITAL ASSOCIATION
ANALYSIS OF MEDICARE IMPACT - FY 1990
RURAL HOSPITAL LESS THAN 100 BEDS
RANKED BY MEDICARE UTILIZATION

	MEDICARE PROVIDER #	HOSPITAL	# BEDS	% MEDICARE	PROJECTED 1990 MEDICARE GAIN/(LOSS) TOTAL (CURRENT LAW)	ESTIMATED TOTAL MEDICARE GAIN/(LOSS) (WITH PROPOSED CUTS)
1	450070	BAYLOR MEDICAL CENTER AT GILMER	46	77.39%	(731,295)	(834,027)
2	450370	COLUMBUS COMMUNITY HOSPITAL	46	70.54%	(813,191)	(866,451)
1	450476	RANGER GENERAL HOSPITAL	42	66.37%	(289,122)	(307,614)
2	450574	CONCHO COUNTY HOSPITAL	20	66.03%	53,577	44,913
3	450053	LAVACA HOSPITAL DISTRICT	34	62.29%	(356,151)	(381,255)
4	450258	PARKVIEW HOSPITAL	43	61.90%	(170,688)	(188,862)
5	450270	LAKE WHITNEY MEMORIAL	75	61.74%	61,780	34,281
6	450438	COLORADO FAYETTE MEDICAL CENTER	43	60.70%	(188,472)	(253,704)
7	450048	ST. EDWARD HOSPITAL	51	60.49%	(175,388)	(199,693)
8	450600	E. L. GRAHAM HOSPITAL	37	60.31%	(388,798)	(402,865)
9	450595	HUBBARD HOSPITAL	32	60.30%	(183,522)	(208,811)
1	450486	CHILDRESS HOSPITAL	35	59.52%	27,914	15,708
2	450004	LINDEN MUNICIPAL HOSPITAL	60	58.19%	(60,712)	(88,514)
3	450288	DE LEON HOSPITAL DISTRICT	45	58.03%	(14,492)	(60,855)
4	450283	COZBY GERMANY HOSPITAL	44	57.99%	(116,753)	(136,228)
5	450547	WOOD COUNTY CENTRAL HOSPITAL	31	57.14%	113,710	87,102
6	450219	LLANO MEMORIAL HOSPITAL	36	57.01%	124,367	102,568
7	450234	COMANCHE COMMUNITY HOSPITAL	27	56.67%	(168,792)	(188,288)
8	450667	STONEWALL MEMORIAL HOSPITAL	28	56.09%	(170,321)	(179,288)
9	450169	SHACKELFORD COUNTY HOSP DISTRICT	29	54.55%	(98,779)	(102,856)
10	450467	MADISON COUNTY HOSPITAL	59	54.46%	(105,555)	(139,481)
11	450306	STAMFORD MEMORIAL HOSPITAL	74	53.98%	(163,866)	(196,516)
12	450373	MT VERNON MEDICAL (FRANKLIN COUNTY)	54	53.08%	(481,444)	(512,624)
13	450108	WILSON MEMORIAL HOSPITAL	51	52.99%	(138,673)	(166,200)
14	450224	PRESBYTERIAN HOSPITAL OF WINNSBORO	54	52.89%	(1,115,723)	(1,228,878)
15	450517	SAN AUGUSTINE HOSPITAL	54	52.46%	(165,419)	(181,520)
16	450583	KIMBLE HOSPITAL	21	51.71%	12,491	3,888
17	450460	TYLER COUNTY HOSPITAL	55	51.70%	65,283	56,745
18	450208	HALL BENNETT MEMORIAL HOSPITAL	52	51.69%	(187,189)	(210,096)
19	450362	SHEPPERD MEMORIAL HOSPITAL	46	50.72%	288,774	256,834
20	450565	PALO PINTO GENERAL HOSPITAL	90	50.35%	105,112	(35,660)
1	450559	GARZA MEMORIAL HOSPITAL	32	49.49%	(298,180)	(304,957)
2	450303	CROSBYTON CLINIC HOSPITAL	46	49.41%	(281,583)	(303,973)
3	450497	BOWIE MEMORIAL HOSPITAL	62	49.16%	(41)	(38,276)
4	450327	SHAMROCK GENERAL HOSPITAL	49	48.57%	(85,079)	(100,843)
5	450648	RICHARDS MEMORIAL HOSPITAL	47	48.24%	(151,112)	(186,996)
6	450694	EL CAMPO MEMORIA	68	48.10%	(973,969)	(1,053,543)
7	450143	SMITHVILLE HOSPITAL AUTHORITY	31	48.09%	160,040	148,959
8	450192	HILL REGIONAL HO	98	47.90%	(456,567)	(560,863)
9	450615	ATLANTA MEMORIAL HOSPITAL	61	47.61%	86,009	52,586
10	450451	HARRIS METH-GLEN ROSE (MARKS ENGLISH)	26	47.42%	(99,046)	(116,153)
11	450357	LOCKHART HOSPITAL	49	47.38%	(251,654)	(285,192)
12	450188	RED RIVER GENERAL HOSPITAL	72	47.29%	(79,561)	(149,469)

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TEXAS HOSPITAL ASSOCIATION
ANALYSIS OF MEDICARE IMPACT - FY 1990
RURAL HOSPITAL LESS THAN 100 BEDS
RANKED BY MEDICARE UTILIZATION

	MEDICARE PROVIDER #	HOSPITAL	# BEDS	% MEDICARE	PROJECTED 1990 MEDICARE GAIN/(LOSS) TOTAL (CURRENT LAW)	ESTIMATED TOTAL MEDICARE GAIN/(LOSS) (WITH PROPOSED CUTS)
13	450727	MITCHELL COUNTY HOSPITAL	45	47.09%	(359,544)	(389,301)
14	450098	PITTSBURG MEDICAL CENTER	57	47.09%	7,507	(28,236)
15	450700	SABINE COUNTY HOSPITAL DISTRICT	46	46.92%	(19,794)	(42,562)
16	450185	COLLINGSWORTH GENERAL HOSPITAL	29	46.89%	41,747	34,066
17	450580	HOUSTON COUNTY HOSPITAL	83	46.32%	410,040	349,978
18	450334	BALLINGER MEMORIAL HOSPITAL	36	46.26%	(90,418)	(105,973)
19	450389	LAKELAND MEDICAL CENTER	89	45.44%	546,841	178,288
20	450081	YOAKUM CATHOLIC HOSPITAL	39	45.15%	(357,542)	(394,831)
21	450493	MAURITZ MEMORIAL HOSPITAL	46	45.11%	(377,630)	(388,962)
22	450649	HEART OF TX (MCCULLOCH COUNTY HA)	56	45.09%	191,457	166,709
23	450243	HAMLIN HOSPITAL DISTRICT	29	44.75%	(330,303)	(347,845)
24	450321	FISHER COUNTY HOSPITAL DISTRICT	30	44.58%	(150,963)	(171,106)
25	450735	SCHLEICHER COUNTY MEDICAL CENTER	18	44.44%	(229,228)	(233,493)
26	450473	MEMORIAL HOSPITAL OF CENTER	66	44.35%	358,679	305,568
27	450055	ROLLING PLAINS MEMORIAL HOSPITAL	70	44.13%	(271,426)	(353,157)
28	450052	GOODALL - WITCHER HOSPITAL FOUNDATION	64	44.04%	242,053	194,773
29	450292	PRESBYTERIAN HOSPITAL OF KAUFMAN	93	43.61%	(1,212,525)	(1,369,848)
30	450337	CHEROKEE MEDICAL CENTER	55	43.00%	110,508	95,534
31	450472	BURLESON COUNTY HOSPITAL DISTRICT	41	42.97%	(318,832)	(353,192)
32	450623	NORTHEAST MEDICAL (FANNIN COUNTY)	70	42.71%	(138,876)	(171,294)
33	450164	BAYSIDE COMMUNITY HOSPITAL	27	42.56%	(244,737)	(256,735)
34	450381	EDGAR B. DAVIS MEMORIAL HOSPITAL	40	42.47%	124,046	105,953
35	450597	CUERO COMMUNITY HOSPITAL	73	42.45%	(202,626)	(241,714)
36	450628	SOUTH LIMESTONE	37	42.10%	(252,428)	(263,830)
37	450513	HOSPITAL ON THE PINES	49	42.09%	(67,217)	(81,064)
38	450450	GOLIAD COUNTY HOSPITAL	32	42.07%	(305,550)	(317,124)
39	450641	NOCONA HOSPITAL DISTRICT	40	41.84%	(163,132)	(174,993)
40	450351	STEPHENVILLE GENERAL HOSPITAL	93	41.78%	(440,372)	(528,313)
41	450218	OVERALL-MORRIS HOSPITAL	51	41.21%	(77,397)	(98,094)
42	450665	OTTO KAISER MEMORIAL HOSPITAL	44	40.79%	(409,182)	(430,236)
43	450286	NAVASOTA REGIONAL HOSPITAL	61	40.59%	(996,117)	(1,037,658)
44	450241	JACK COUNTY HOSPITAL	52	40.30%	(61,469)	(69,971)
45	450230	ARCHER COUNTY HOSPITAL	31	40.23%	(147,149)	(153,381)
1	450369	CHILDRESS GENERAL HOSPITAL	59	39.81%	126,709	99,034
2	450187	ST. JUDE HOSPITAL	75	39.77%	(457,293)	(518,564)
3	450253	BELLVILLE HOSPITAL AUTHORITY	38	39.63%	61,790	33,067
4	450596	HOOD GENERAL HOSPITAL	69	39.56%	(994,155)	(1,073,104)
5	450679	LEON COUNTY MEMO	41	39.30%	(158,862)	(221,265)
6	450498	STEPHENS MEMORIAL HOSPITAL	61	39.22%	(29,958)	(48,813)
7	450411	EASTLAND MEMORIAL HOSPITAL	93	39.21%	29,123	7,803
8	450400	HARRIS METH MEXIA (GENERAL MEXIA)	76	39.18%	31,927	(140)
9	450557	CAPROCK HOSPITAL DISTRICT	43	39.16%	(229,980)	(243,107)
10	450275	DAVID GRANBERRY MEM HOSP	35	38.65%	111,204	90,849
11	450586	SEYMOUR HOSPITAL AUTHORITY	49	38.46%	(400,108)	(424,646)
12	450609	LYNN COUNTY HOSPITAL	29	38.45%	35	(10,088)

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TEXAS HOSPITAL ASSOCIATION
ANALYSIS OF MEDICARE IMPACT - FY 1990
RURAL HOSPITAL LESS THAN 100 BEDS
RANKED BY MEDICARE UTILIZATION

	MEDICARE PROVIDER #	HOSPITAL	# BEDS	% MEDICARE	PROJECTED 1990 MEDICARE GAIN/(LOSS) TOTAL (CURRENT LAW)	ESTIMATED TOTAL MEDICARE GAIN/(LOSS) (WITH PROPOSED CUTS)
13	450166	LILLIAN M. HUDSPETH MEMORIAL HOSP	28	38.25%	(64,453)	(68,353)
14	450151	FAYETTE MEMORIAL HOSPITAL	66	38.06%	(140,028)	(169,193)
15	450475	HENDERSON MEMORIAL HOSPITAL	83	37.82%	1,243,282	1,115,017
16	450332	HARRIS METH-DUBLIN (DUBLIN MED)	32	37.78%	(40,905)	(76,767)
17	450235	MEMORIAL (GONZALES COUNTY HD)	49	37.34%	(23,631)	(52,113)
18	450309	MEDINA COMMUNITY HOSPITAL	44	37.03%	85,613	66,712
19	450063	PARMER COUNTY COMMUNITY HOSPITAL	36	36.70%	(126,921)	(132,085)
20	450041	ROLLINS-BROOK HOSPITAL	27	35.85%	91,336	85,781
21	450276	CLAY COUNTY MEMORIAL	50	35.55%	(280,017)	(299,481)
22	450604	HILL COUNTRY MEMORIAL HOSPITAL	66	35.41%	716,107	645,887
23	450090	GAINESVILLE HOSPITAL DISTRICT	62	34.71%	(650,160)	(733,868)
24	450278	CHILLICOTHE HOS DIST	34	34.52%	(216,759)	(225,450)
25	450355	COON MEMORIAL HOSPITAL	29	34.07%	(372,096)	(387,931)
26	450082	BEEVILLE MEMORIAL HOSPITAL	81	33.84%	(142,487)	(181,021)
27	450626	EDNA HOSPITAL	36	33.82%	(81,262)	(95,023)
28	450464	HASKELL MEMORIAL HOSPITAL	30	33.19%	(165,316)	(171,405)
29	450022	MEMORIAL HOSPITAL	93	32.97%	(430,285)	(451,074)
30	450050	WARD MEMORIAL HOSPITAL	57	32.50%	(266,223)	(299,292)
31	450177	UVALDE COUNTY HOSPITAL AUTHORITY	74	32.30%	182,780	140,603
32	450698	LAMB HEALTHCARE (LITTLEFIELD HOSP)	74	31.97%	(224,160)	(291,115)
33	450182	SOUTH PLAINS HOSPITAL & CLINIC	43	31.87%	(33,631)	(52,112)
34	450271	DECATUR COMMUNITY HOSPITAL	55	31.84%	16,725	(13,467)
35	450281	BOHNE MEMORIAL HOSPITAL	72	31.81%	(400,996)	(455,046)
36	450127	LEE MEMORIAL HOSPITAL	32	31.69%	(236,561)	(248,787)
37	450429	HI PLAINS HOSPITAL	48	31.67%	134,271	122,618
38	450085	GRAHAM GENERAL HOSPITAL	47	31.55%	322,977	291,786
39	450146	HANSFORD COUNTY HOSPITAL DISTRICT	36	30.51%	(78,810)	(89,077)
40	450374	COCHRAN MEMORIAL HOSPITAL	38	30.44%	(191,000)	(197,567)
1	450178	PECOS COUNTY MEMORIAL HOSPITAL	45	28.54%	(154,766)	(175,656)
2	450620	DIMMIT COUNTY MEMORIAL HOSPITAL	55	27.79%	645,056	621,847
3	450170	NORTH RUNNELS CO. HOSP. DIST.	30	27.25%	(102,079)	(110,610)
4	450492	NEWTON COUNTY MEMORIAL HOSPITAL	42	27.09%	152,247	144,719
5	450322	PECOS COUNTY GEN (IRAAN GENERAL)	19	26.56%	(115,798)	(118,881)
6	450658	FAIRFIELD MEMORIAL HOSPITAL	49	26.05%	(212,669)	(236,229)
7	450014	CHAMP TRAYLOR MEMORIAL HOSPITAL	83	25.91%	194,844	187,071
8	450613	METHODIST HOSP-LEVELLAND (COOK MEM)	82	25.06%	(657,735)	(722,463)
9	450109	MUENSTER MEMORIAL HOSPITAL	37	24.83%	224	(9,590)
10	450654	STARR COUNTY MEMORIAL HOSPITAL	52	24.61%	192,978	180,045
11	450293	FRIO HOSPITAL	27	24.58%	(41,524)	(51,150)
12	450578	HEMPHILL COUNTY HOSPITAL	31	24.22%	(151,892)	(160,352)
13	450726	BROOKS COUNTY HOSPITAL	38	23.99%	180,371	169,035
14	450077	WINTER GARDEN MEDICAL CENTER	43	23.56%	14,443	6,875
15	450181	YOAKUM COUNTY HOSPITAL	45	23.37%	(269,573)	(276,348)
16	450264	SWISHER MEMORIAL HOSPITAL	35	22.63%	10,227	5,656
17	450078	ANSON GENERAL HOSPITAL	53	22.54%	(381,476)	(393,498)

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TEXAS HOSPITAL ASSOCIATION
ANALYSIS OF MEDICARE IMPACT - FY 1990
RURAL HOSPITAL LESS THAN 100 BEDS
RANKED BY MEDICARE UTILIZATION

	MEDICARE PROVIDER #	HOSPITAL	# BEDS	% MEDICARE	PROJECTED 1990 MEDICARE GAIN/(LOSS) TOTAL (CURRENT LAW)	ESTIMATED TOTAL MEDICARE GAIN/(LOSS) (WITH PROPOSED CUTS)
18	450221	MEMORIAL HOSPITAL	80	22.54%	272,117	247,332
19	450141	HICO CITY HOSPITAL	23	21.62%	(64,951)	(68,056)
20	450217	HALL COUNTY HOSPITAL	48	21.13%	(69,030)	(75,314)
21	450269	PLAINS MEMORIAL HOSPITAL	49	20.74%	(172,813)	(181,274)
1	450092	MAVERICK COUNTY HOSPITAL	89	17.37%	(291,808)	(327,986)
2	450160	MEMORIAL HOSPITAL	36	17.23%	(334,460)	(344,171)
3	450263	TRINITY MEMORIAL HOSPITAL	36	16.46%	(82,343)	(86,536)
4	450206	MARY E. DICKERSON MEMORIAL HOSPITAL	54	16.22%	28,921	6,342
5	450341	BAPTIST HOSPITAL (MEDICAL CNTR)	60	13.78%	43,366	35,784
6	450632	LOCKNEY GENERAL HOSPITAL	26	13.54%	(28,352)	(32,358)
7	450250	THROCKMORTON COUNTY HOSPITAL	24	13.01%	(84,509)	(86,366)
8	450307	MARTIN COUNTY HOSPITAL	29	12.02%	(123,752)	(130,170)
9	450534	OCHILTREE GENERAL HOSPITAL	71	11.21%	(194,635)	(200,966)
10	450741	HUBBARD HOSPITAL	30	10.61%	(51,023)	(53,200)
11	450201	REEVES COUNTY HOSPITAL	78	10.44%	(158,211)	(166,945)
12	450246	WAGNER GEN (UNIT-MATAGORA COUNTY)	49	9.29%	(348,186)	(363,843)
13	450343	HAMILTON GENERAL HOSPITAL	51	8.50%	(93,446)	(97,036)
14	450607	REAGAN MEMORIAL HOSPITAL DISTRICT	33	8.14%	10,987	9,715
15	450527	CENTRAL TEXAS MED (HAYS MEMORIAL)	39	6.58%	(168,358)	(186,892)
16	450603	CULBERSON COUNTY	31	6.45%	(58,124)	(59,338)
17	450712	STARLITE VILLAGE HOSPITAL	13	5.75%	9,643	8,539
18	450249	QUANAH MEDICAL (HARDEMAN COUNTY)	54	4.73%	(41,442)	(50,629)
155			7,602		(19,010,385)	(23,672,404)

Source: HCFA-PPS 4

Attachment 2

02-May-89

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TEXAS HOSPITAL ASSOCIATION
ANALYSIS OF MEDICARE MARGINS (PPS1 - PPS7)
RURAL HOSPITALS
(INCLUDES PASSTHROUGHS)

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	PPS-1 *	PPS-2 *	PPS-3 *	PPS-4 *	1990 PROPOSAL (CURRENT LAW) PPS-7 **	1990 PROPOSAL (BUDGET PROPOSAL) PPS-7 **
RURAL HOSPITALS	227	218	219	211	185	185
RURAL DISCHARGES	160,698	127,363	110,916	99,899	96,845	96,845
RURAL REVENUE	327,391,889	305,280,543	280,687,222	276,091,176	325,819,172	317,076,785
RURAL COSTS	314,541,704	298,796,441	292,853,137	293,823,554	360,011,538	360,011,538
RURAL PROFIT	12,850,185	6,484,102	(12,165,915)	(17,732,378)	(34,192,366)	(42,934,753)
% RURAL PROFIT (% REV)	3.93%	2.12%	-4.33%	-6.42%	-10.49%	-13.54%
REV PER DSCH-RURAL	2,037.31	2,396.93	2,530.63	2,763.70	3,364.34	3,274.06
COSTS PER DSCH-RURAL	1,957.35	2,346.02	2,640.31	2,941.21	3,717.40	3,717.40
TOTAL	79.96	50.91	(109.69)	(177.50)	(353.06)	(443.33)
DSCH PER HOSP-RURAL	708	584	506	473	523	523

* - MEDICARE COST REPORTS
** - TEXAS HOSPITAL ASSOCIATION

PREPARED STATEMENT OF SENATOR GEORGE J. MITCHELL

Mr. Chairman, I commend you for scheduling this hearing today to address the issue of Medicare reimbursement to rural hospitals and for the leadership you have shown in the introduction of the Equity for Rural Hospitals Act of 1989, which is intended to eliminate many of the existing inequities in the Medicare Prospective Payment System which affect rural hospitals.

Since the implementation of the Medicare Prospective Payment System in 1983, the nation's rural hospitals have experienced an increasingly difficult time in continuing to provide access to quality care in rural areas.

The differential in Medicare payment to rural hospitals has been at the center of the difficulties faced by small rural hospitals in Maine and across the country.

Within the last year, two of Maine's forty-two hospitals have closed—both were small, rural facilities.

The Maine Hospital Association estimates that there is a shortfall of more than $60 million between costs of services provided by hospitals to Medicare patients and reimbursements to hospitals for those services from the Federal Government.

In order to make up for the shortfall in Medicare payments, Maine hospitals have increased their charges to private paying patients. This "cost-shifting" has contributed to rapidly escalating premiums for private health insurance, borne mostly by employers and employees.

Some hospitals in my State have increased their charges to private paying patients by as much as 30% to make up for the shortfall. Because small rural hospitals often serve a disproportionate share of Medicare and Medicaid patients, it is often the smallest, most rural hospitals that have the highest charges for private beds. Therefore many persons with private health insurance who can afford to travel to a larger hospital in Portland or Bangor can be cared for at significantly lower cost.

This is clearly a problem which affects not only the fiscal viability of our nation's small rural hospitals, but one which affects the cost of health care for all Americans.

Senator Bentsen's bill attempts to address this problem by including a provision which requires the Secretary to design a legislative proposal to eliminate Medicare's current disparity between payment rates for hospitals in rural, large urban and other urban areas.

While the implementation of such a payment scheme will be difficult in these times of fiscal austerity, it is important that we develop the methodology to eventually achieve this goal.

The Secretary would also be required to recommend a severity adjustment to reflect differences in severity among cases in the same diagnosis-related group. The lack of a severity adjustment has been one of the most serious shortcomings in the prospective payment system.

Other provisions in this bill expand demonstrations programs to encourage physicians to do their clinical training in rural areas and provide expanded Medicare payments for training undergraduate nurses.

Clearly, the shortage of physicians who are willing to serve in rural hospitals and nurses in all health care settings, seriously jeopardize access to quality care for the elderly living in rural areas.

I join Senator Bentsen as a cosponsor of this bill because I am committed to maintaining the fiscal viability of our small rural hospitals.

We must make sure that all citizens, including those living in rural America, continue to have access to quality care. I look forward to the testimony to be presented here today and hope that it will provide us with guidance as we continue to work toward that goal.

PREPARED STATEMENT OF SENATOR LARRY PRESSLER

Mr. Pressler: Mr. Chairman, I want to thank you for this opportunity to provide testimony to the Senate Finance Committee on the issue of medicare reimbursement to rural hospitals. This issue is extremely important to me. I am reminded every day by hospital administrators, physicians and consumers of the importance of hospitals to rural South Dakota.

In January, I joined other Senators in a public commitment to protect hospitals from further cuts in Medicare. Medicare was established as an insurance program to pay the cost of caring for those 65 and older. Today, medicare is a "tax" on the private-pay patient and the private-insurance companies. Medicare is not paying its own way. The difference between what Medicare pays and the cost of providing care is shifted to the private payor and privately-insured individuals. That is a "tax." Our urban hospitals in South Dakota must charge a minimum 37 cents extra for every dollar of care they provide to private-pay patients and private insurance companies in order to finance the cost of caring for medicare patients.

Urban hospitals in South Dakota currently have a sufficient number of non-medicare patients so they can shift the cost of caring for medicare patients in order to continue providing quality care. However, small rural hospitals of under 50 beds are in trouble. They cannot shift costs like urban hospitals in rural States can.

Small, rural hospitals treat a higher number of elderly. As a result, they receive at least 60 to 75 percent of their revenues from Medicare. Further, Medicare reimbursement rates to small, rural facilities is lower than for the urban facilities. To make matters even worse, the number of private-pay patients and privately insured patients is less. Therefore, the higher cost of providing care to medicare patients in those hospitals cannot be shifted readily to non-medicare patients. If the total cost of taking care of medicare patients in small rural hospitals were shifted to non-medicare patients, their costs would be so high the care would be totally unaffordable. That is why small, rural hospitals face financial disaster. That is why those hospitals are closing in many rural areas like South Dakota.

I believe we must take action on two fronts immediately: (1) provide adequate reimbursement to stop the cost shifting; and (2) eliminate the rural/urban reimbursement differential. Without those two actions, our small rural hospitals will close and our urban hospitals in rural areas will face financial hardship.

S. 306, the "equity for rural hospitals act" would eliminate the rural/urban differential and replace it with a single national rate. We cannot afford a reduction in Medicare. If we accept the proposed $2.7 billion cut in Medicare, elimination of the differential will be hard to achieve. Soon there no longer may be enough small rural hospitals left to worry about. I will resist cuts in Medicare. The people who would be hurt the most are the elderly. They represent the highest proportion of non-farm families living in rural america. They are also the ones who lack access to other key resources, such as transportation to larger urban centers. We must act now to turn the tide.

Another positive note in this bill is its extension of the rural health care transition grants program. Many of our rural hospitals could use that money to restructure and position themselves for the delivery of primary care services in an era of restricted financial and human resources. Ten hospitals in South Dakota submitted applications for these funds this year. I understand that more than 800 applications were received by the health care financing administration, and of those 800 only 84 will be funded. The chances of even one being funded in South Dakota are remote. We need to give more rural areas the opportunity to obtain these funds. We need to assist them in this era of reduced resources to continue providing primary care services.

I support assistance to physicians and nurses who are absolutely necessary for providing care. Without physicians no hospital will stay open. Therefore, we must give consideration to supporting those physicians who want to practice in rural areas.

I am committed to fighting all reductions in medicare funding to hospitals and for elimination of the rural/urban reimbursement differential. We must begin today or forget about tomorrow. Unless we do, there will be no tomorrow for the small rural hospital.

PREPARED STATEMENT OF SENATOR DAVID PRYOR

Mr. Chairman. I would like to commend you, once again, for focusing needed attention on the plight of rural hospitals. Although there is a border line between your home State and mine, little else separates us on this important issue. For that matter, little separates us from the other Members of this Committee on this issue.

In Arkansas, and across the nation, we have witnessed a restructuring of our health care delivery system. We have seen hospital after hospital close. Some have argued that these closures were necessary to make the health care delivery system more efficient by cutting waste and duplication. In some cases, that may be true. However, we have reached the stage now where we have cut through the fat and reached the bone. I fear that if we do not intercede soon, we may ultimately amputate one of the legs that holds our rural health care system together. Once that occurs, no matter how skilled we are as public health policy surgeons, we will not be able to mend the wound.

Hospitals in rural areas play such an important role in their communities beyond the care actually provided within the confines of their walls. In addition to their economic contribution to the community, these hospitals attract desperately needed health care personnel. Practicing privileges in a hospital ranks among the most important factors that doctors cite when choosing a practice location. As a result, a community without a hospital or at least without relatively easy access to a hospital often finds itself also without needed health care personnel. Limited access to health care personnel obviously translates into limited access to health care—an outcome we cannot accept.

Financial pressures have completely overwhelmed many rural hospitals and continually threaten the existence of numerous others. Between 1980 and 1987, 161 rural community hospitals were forced to close. In 1988, three of the 43 rural hospitals that closed were located in my home State of Arkansas. What's more, over half of the 80 rural hospitals in Arkansas are reporting that they are having serious financial difficulties. It certainly does not require an accountant to conclude that rural hospitals cannot continue to exist under these conditions. In fact, it is my understanding that the Arkansas Hospital Association projects that an additional 5 to 10 Arkansas hospitals will close within the next five years unless something dramatic occurs.

As Chairman of the Senate Special Committee on Aging, I am deeply concerned about the impact rural hospital closures are having on the elderly. Older Americans make up a large and growing percentage of the rural population and rural hospitals play a particularly vital role in their lives. For that same reason, Medicare reimbursement policies are of increasing importance to rural hospitals.

Recognizing the need to develop constructive Federal rural health care policy, the Aging Committee has actively focused a great deal of congressional and public attention on the magnitude of this problem. In 1988 alone, I had the pleasure of chairing one of the three hearings the Committee held on this issue in Pine Bluff, Arkansas. In addition, at the end of the year, the Committee released a substantive report entitled "The Rural Health Care Challenge," which has come to be known in some health policy circles as the "rural health care bible." In fact, Mr. Chairman, I would ask unanimous consent that the Executive Summary of this report appear immediately following my Statement.

Our hearings and report repeatedly focused attention on unfair Medicare policies. For the exact same diagnosis, Medicare reimburses rural hospitals at a significantly lower rate than their urban counterparts. Not surprisingly, rural hospitals are not faring well under this discriminatory reimbursement system. In fiscal years 1984 through 1986, about 83 percent of all hospitals losing money under Medicare were in rural areas.

Mr. Chairman, I know that you and I have reached the same conclusion. I applaud your introduction of the Equity for Rural Hospitals Act of 1989 that begins to seriously address this situation. I was pleased to join you as an original cosponsor of this effort that would work to phase out the urban-rural Medicare hospital differential that we have all heard so much about. In addition, the bill directs the Secretary of Health and Human Services to develop specific recommendations for improving the special considerations given to teaching hospitals, rural referral centers, sole community hospitals, disproportionate share hospitals, and outlier cases.

Despite this encouraging news, there remain many many problems confronting rural hospitals. In particular, I believe we should try to find ways to expedite the elimination of the Medicare urban-rural differential.

This year I look forward on working with you on addressing not only the many high priority rural hospital issues, but also on the issues surrounding the critical problem of attracting and retaining needed primary health care personnel in rural medically underserved communities. There is no question that the quality, strength, and survival of these vital primary care services are directly correlated with and depend on a reliable level of hospital accessibility. At the same time, referrals and efficient use of hospital services generally depend on the quality and accessibility of primary care services. I am actively looking at ways to address this side of the rural health equation and look forward to working with you and other Members of the Committee, as well as the Labor and Human Resources Committee, in developing the best approaches to attracting and retaining needed health care personnel.

Mr. Chairman, I look forward to continuing to work with you and other members of the Finance Committee, as well as the Senate and House Rural Health Caucuses, to resolve the many pressing concerns for the health of rural Americans.

Enclosure.

THE RURAL HEALTH CARE CHALLENGE, STAFF REPORT TO THE SPECIAL COMMITTEE ON AGING, U.S. SENATE, OCTOBER 1988

- DHHS has been negligent in their responsibility to provide Congress with needed and timely data on what role Medicare and other Federal health care policy decisions have played in terms of maintaining or improving access to medical care in rural areas.
- DHHS identified 1,292 rural primary care shortage areas in March 1988, requiring 1,792 practitioners. Further, a 1988 survey suggests that as many as 25 percent of rural physicians may retire or leave their communities within the next five years.
- Although greater overall numbers of physicians have contributed to notably increased numbers of physicians practicing in rural counties with a population over 10,000 people, rural counties which have populations under 10,000 have not similarly benefited.
- Rural areas dependent upon the services of a National Health Service Corps (NHSC) physician will find it increasingly difficult to secure a replacement when their current physician has met his/her commitment. The number of prior scholarship recipients available for service in 1989 is estimated at 222 (in contrast, 1,400 scholarship physicians were available for service in 1985). No new scholarships will be issued in 1989. While the Corps recruits physicians in other ways, the Corps' field strength is expected to drop dramatically.
- Rising malpractice premiums have resulted in an increasing number of rural counties losing all obstetrical services; Florida is a particularly dramatic example where obstetrical care is no longer offered in a majority of the State's rural counties.
- The nation's 357 rural community health centers and 117 migrant health centers are an important source of primary care for the non-poor as well as the poor in many rural communities. For this important part of the health care "safety net", Federal funding has not kept pace with inflation. Moreover, the centers have experienced a dramatic increase in both the number of uninsured patients and their malpractice premiums in recent years.

Causes of Health Crisis in Rural Communities

COMMUNITY CHARACTERISTICS:

- Rural communities often have characteristics that make it more difficult to provide health care to their residents. These include:

(1) Not only is a higher percentage of the rural population uninsured (17% rural vs. 14% urban) but a higher percentage of rural Americans are uninsured at every income level. Only one-fourth of the rural poor qualify for Medicaid, compared to 43 percent of the poor in inner cities.

(2) A disproportionate share of the rural population is poor; the rural poverty rate grew throughout the first half of the 1980's, reaching 18.3 percent in 1985, compared to an urban poverty rate of 12.7 percent.

(3) While the elderly comprise 12 percent of the total population in the United States, they account for 25.4 percent of the population in rural communities.

(4) Beginning in 1980, the rural unemployment rate consistently has exceeded the urban rate, a reversal of the historical pattern.

(5) Rural population growth has slowed dramatically as migration to urban areas has hit its highest level in three decades (632,000 in 1985–1986), resulting in a declining patient base for rural health care providers. If this trend continues, rural America may soon experience negative population growth.

CHALLENGES FACING RURAL HOSPITALS

- Medicare's reimbursement policies have contributed to eroding the financial viability of rural hospitals. Rural hospitals, particularly small rural hospitals, have been hurt by the following policies:

(1) Maintaining a Medicare payment rate for rural hospitals which, for the exact same diagnosis, is 14.5% lower than the payment rate for urban hospitals;

(2) Assuming that all rural hospitals in a State have the same wage index (while urban hospitals receive a wage index specific to their area);

(3) Failing to provide adequate financial support for hospitals which are the community's sole source of care (sole community hospitals)

(4) Establishing difficult to meet qualification thresholds for assistance on unusually high cost cases ("outlier" cases), revenue "losers" which are much more difficult for small hospitals to absorb; and

(5) Failing to recognize the vulnerability of low-volume small rural hospitals to a payment system which leaves them at complete risk for fluctuations in admissions and costs.

Issues of Medicare reimbursement only add to the difficulties that most rural hospitals already face. Like all hospitals, rural hospitals face declining utilization of inpatient services, cost containment pressures brought on by public and private insurers alike, as well as increased competition for patients. However, rural hospitals face additional pressures as well:

(1) Smaller hospitals, which are based predominantly in rural areas, cannot take advantage of economies of scale because they simply do not have the necessary patient volume. Increased migration to urban areas exacerbates this problem.

(2) Disproportionately high levels of unemployment, poverty, and uninsuredness can undermine the viability of small rural hospitals by (1) creating financial barriers to demand which deprive hospitals of admissions and ((2) increasing the demand for uncompensated care, thus producing increased levels of bad debt.

(3) Sole community hospitals and "frontier" hospitals (located in counties with fewer than 6 persons per square mile) often face substantial costs for infrequently used standby equipment and personnel.

CHALLENGES OF ATTRACTING AND RETAINING RURAL HEALTH CARE PERSONNEL

- For many reasons, rural communities have always been plagued by shortages of health care personnel. These include:

(1) Inadequate and inequitable reimbursement rates and the difficulty in developing an economically viable practice in areas of low population density. Because Medicare physician reimbursement rates are based on historical and geographical charge rates, payments to physicians in rural areas are less than those practicing in urban areas;

(2) Fear of professional isolation and a lack of modern medical facilities, equipment or local referral laboratories;

(3) Inability to find acceptable employment for a professional spouse; and

(4) The fear that practice in rural areas may well prove to be a 24-hour job with inadequate back-up support.

As a result, rural communities have been forced to offer physicians bonuses or guaranteed salaries to induce them to relocate and, when that has failed and if possible, small isolated rural communities have been forced to rely upon physicians placed in their community by the National Health Service Corps.

Major Recommendations for Congressional Consideration—Rural Hospitals

CHANGES IN MEDICARE REIMBURSEMENT POLICY

- Eliminate the 14.5% differential in urban and rural hospital payments.
- Annually survey hospital wages and develop a more appropriate wage index for rural hospitals without any further delay.
- Simplify and streamline the process by which hospitals qualify for financial assistance when they have experienced large declines in patient volume.
- Because of the importance for maintaining access to health care for Medicare beneficiaries in underserved areas, develop alternative reimbursement options for sole community hospitals, including removing sole community hospitals from the PPS system and returning them to a cost reimbursement basis.

RESEARCH

- To address the void of needed data on important aspects of the Medicare program, establish a PPS research agenda for the Office of Rural Health Policy and the Prospective Payment Assessment Commission to assure answers to the major questions affecting the equity of PPS for rural hospitals such as:

—sole community hospital protections;
—protections for rural hospitals from high cost cases (outliers);
—the source of higher urban hospital costs; and
—the effectiveness of volume protection provisions.

- Provide full funding ($10 million) to the National Center for Health Services Research to fund the rural health services research agenda recommended by the Rural Health Services Research Conference.
- Establish a Federal clearinghouse for rural health services research under the auspices of the Office of Rural Health Policy. Innovative and successful approaches to health services delivery in rural areas should be documented and catalogued so that other rural communities can emulate them.

Rural Health Care Personnel

CHANGES IN MEDICARE POLICY

- Eliminate the geographical distinctions in Medicare payments for physician services.

IMPROVING THE SUPPLY OF RURAL HEALTH CARE PROFESSIONALS

- Emphasize Federal support for health professions training on support for primary care training for individuals who reside in rural or underserved areas and are most likely to return to these areas to practice.
- Provide at least $8-$10 million in funding for National Health Service Corps (NHSC) scholarships and the loan repayment program to begin to address critical personnel shortages of physicians, nurses and dentists.
- To increase the likelihood that the NHSC loan repayment program is successful, emphasize targeting physicians who have received part of their training in rural areas.
- Expand programs that provide training for health care personnel in rural areas (such as the Area Health Education Program).

BUILDING AN INFRASTRUCTURE FOR HEALTH CARE DELIVERY

- Expand Federal support for rural community health centers (CHCs) and conduct an evaluation of the appropriateness of the CHC model for serving sparsely populated "frontier" counties.
- To address the fact that the percentage of community mental health centers (CMHC's) serving rural counties has declined over time, finance the expansion of the number of CMHC's in rural areas and provide funding to existing community health centers to begin offering mental health services.
- Extend additional malpractice protection to community and migrant health center physicians to enable them to provide obstetrical services in the growing number of rural counties without such services.
- Expand the Rural Health Clinic Act program by revising and streamlining the criteria for designation, providing automatic certification to community and migrant health centers operating in rural shortage areas and easing the criteria for nurse practitioners now that they are in short supply in rural areas.
- Provide funding for the expansion of the USDA's Agricultural Extension Service crisis counseling service to permit the program to serve all States rather than the eight States now serviced.

RESEARCH

- Direct DHHS to include in all of their health professions reports, an analysis of changes in personnel supply in rural areas.
- Conduct specific analyses on shortages of allied health personnel, particularly in areas such as home health care and nursing home care, which are of vital concern to Medicare beneficiaries.

Prepared Statement of Paul Rettig

A PROFILE OF RURAL HOSPITALS

Mr. Chairman, I am Paul Rettig, executive vice-president of the American Hospital Association and director of its Washington office. On behalf of the American Hospital Association (AHA) and its nearly 5,500 member hospitals, I am pleased to comment on the many issues facing the nation's rural hospitals.

To rural Americans, the local hospital is often much more than a source of health care—it is a mainstay of the community economy. The rural hospital is frequently the largest or second-largest employer in the community, and its presence is often critical in attracting physicians, as well as other business and industry, to the community. In addition to providing personalized health care services at a reasonable cost, rural hospitals provide many valuable services, such as transportation for the elderly, home-delivered meals, and meeting facilities.

In rural areas, it is essential that some health care services be available locally. Otherwise, poor road conditions, adverse weather, or lack of adequate transportation could result in life-threatening situations for the sick or injured.

Yet, despite the invaluable role that rural hospitals play in their communities, their future is at risk.

Size and Distribution

Although similar in being located outside of metropolitan areas, rural hospitals are extremely diverse. They come in all shapes and sizes, and almost all services offered by an urban hospital are also offered by some rural hospital. In general, of course, the range of services offered by rural hospitals is somewhat narrower than the range of services offered by urban hospitals, reflecting the smaller average size of hospitals in rural areas. One important difference between urban and rural hospitals is that rural hospitals are more likely to offer both acute inpatient care and skilled nursing or other forms of inpatient long term care. Nearly 20 percent of rural hospitals operate some skilled nursing beds.

Rural hospitals are, on average, substantially smaller than hospitals located in urban areas. The average rural hospital operates 83 beds, and 50 percent of all rural hospitals operate 62 or fewer beds. Although rural hospitals tend to be small, more than 700 rural hospitals operate more than 100 beds, and more than 173 rural hospitals operate more than 200 beds.

While most rural hospitals are located in midwestern and southwestern States, rural hospitals are found in nearly every State in the nation. Those located in the east, and particularly the northeast, tend to be substantially larger than average, and tend to have operating characteristics closer to those of urban hospitals than to those of rural hospitals located in the west.

Facilities, Services and Utilization

More than 1,400 of the nation's rural hospitals are the only hospital located in their county. Although residents of the county may, and do, choose to receive some hospital care from hospitals located in urban areas or in adjacent counties, the local hospital is the only source of immediate medical care. Furthermore, the local hospital is the vital factor in attracting and retaining all types of health care professionals, particularly physicians, to rural communities.

As noted above, rural hospitals tend to be relatively small. Each year, the typical rural hospital admits 2,300 patients and provides more than 18,800 outpatient visits. Rural hospitals operating fewer than 50 beds, on average, annually admit 822 patients and provide 7,300 outpatient visits, or nearly 20 visits per day.

Rural hospitals have been particularly hard hit by the recent shift of care from inpatient to outpatient settings. Since 1984, the average daily census of rural hospitals has fallen 14 percent, from 141,272 patients to 120,004 patients in 1987. Over this same period, outpatient visits to rural hospitals have increased more than 20 percent, reaching nearly 47 million. The result is that inpatient occupancy rates of rural hospitals, which have been historically low, fell to 55 percent in 1987. Occupancy rates are lowest in the smallest hospitals; rural hospitals operating fewer than 25 beds have an occupancy rate of approximately 30 percent.

Finances and Financial Status

The average budget of a rural hospital is $7.7 million; the average budget of a rural hospital with fewer than 50 beds is $1.4 million. The typical rural hospital has 125 full-time-equivalent employees, including 59 nurses; the typical rural hospital with fewer than 50 beds has 67 full-time-equivalent employees. As one of the largest employers and a critical component in attracting other businesses, the local hospital's importance is increasing as other components of the rural economy are experiencing severe economic distress.

The operating margins of rural hospitals have always been low, but have recently fallen precipitously. On average, revenues from patient services fell short of costs by three percent, or a total of $525 million. Overall margins, taking into consideration revenues from all sources, fell from 4.3 percent in 1984 to 3.2 percent in 1987. By 1987, nearly three of four rural hospitals had patient revenues that fell short of the costs incurred in caring for patients, and more than two of five rural hospitals had negative total revenue margins. One compelling factor influencing these low margins is the disproportionate impact of even one expensive outlier case on a small facility.

RURAL HOSPITALS UNDER PROSPECTIVE PAYMENT

The disparity in operating margins of rural hospitals under PPS has attracted comment since figures first became available. Relative to urban hospitals, rural hospitals have operated at consistently lower margins, although the disparity has been about the same since the second year of PPS.

Actual Experience through PPS Year Four

The most recent figures, for the fourth year of operation under PPS, show a PPS margin for rural hospitals of a negative 2.5 percent. These figures are based on total payments of $3.6 billion to rural hospitals and total costs of $3.7 billion incurred by rural hospitals in caring for Medicare patients. This overall margin figure largely reflects the experience of larger rural hospitals. The average rural hospital incurred a PPS operating deficit of 6 percent in the fourth year of PPS.

Although informative, averages conceal as much as they reveal. In the fourth year of operation under PPS, nearly 56 percent of rural hospitals experienced losses. More than 33 percent of rural hospitals operated with a PPS-related deficit of 10 percent or more. Very small rural hospitals incurred larger deficits than larger rural hospitals. The average fourth year PPS margin for rural hospitals operating fewer than 50 beds was negative 5 percent. Nearly 60 percent of these hospitals incurred deficits in PPS year four, and nearly 20 percent of these hospitals experienced a deficit of more than 10 percent. The low margins of rural hospitals are indicative of hospitals across the country; in fact, more than two-thirds of all hospitals are expected to lose money treating Medicare patients in FY 1990.

Projected Status: FY 1990

Looking ahead to the status of rural hospitals in FY 1990, the year for which Congress is currently debating policy, the projected deficit of rural hospitals is expected to exceed 9 percent, and nearly 45 percent of rural hospitals are expected to experience a PPS-related deficit of 10 percent or more. These projections take into account changes in policy that have already been enacted by Congress. These changes in policy appear to have done much to equalize the relative position of rural and urban hospitals, but have done so by placing urban hospitals in nearly as bad a position as rural hospitals. The projected FY 1990 operating deficit of hospitals located in urban areas of under one million population is 6 percent, while the projected deficit for hospitals in urban areas with populations of one million or more is 11 percent.

RECOMMENDATIONS

The facts and figures on rural hospitals raise two issues. The first concerns the extent to which Medicare is adding to the fiscal pressures on already-strained hospitals. The second concerns changes in the financing and delivery system that may be needed to ensure continued access to appropriate, high-quality medical care for rural communities.

Changes in Medicare Policy

Many individuals and entities involved in health care policy continue to debate the future direction of the health care system. As a practical matter, insofar as Medicare hospital payment policy is concerned, improvement of PPS appears to be the only option in the short-term, or for FY 1990. The most important objective for Medicare is to make sure that payments to rural hospitals are both adequate and equitable.

Unfortunately, as a result of the deficit dilemma, past efforts toward this objective have been implemented in a budget-neutral manner, which often means robbing Peter to pay Paul. For example, urban hospital payments have been reduced to increase rural hospital rates, and teaching hospital payments have been reduced to increase rates paid to hospitals serving large numbers of low-income patients. While these changes were effected more easily in a budget-neutral manner in the early years of PPS when most hospitals experienced positive operating margins, we simply cannot continue to operate under these circumstances when nearly two-thirds of the hospitals in the nation are suffering losses treating Medicare beneficiaries.

Adequacy of Payment

Over time, Medicare payments to hospitals must bear a reasonable relationship to costs incurred in providing needed medical care to patients. To achieve this goal, AHA recommends that payments be recalculated periodically based on current cost data. AHA believes that such a recalculation should include a recognition of costs associated with providing care to the medically indigent, as well as an appropriate level of funding to underwrite the risk experienced by hospitals under a fixed per-case payment system.

Rates should be recalculated every four years using an expanded definition of the cost of caring for Medicare patients. Between these quadrennial recalculations, prices should be updated by the percentage increase in the price of goods and services that hospitals must purchase to provide care. For providers exempt from PPS, a more timely means of adjusting payment limits of individual providers for changes in case mix and treatment is needed.

This recommendation is a significant change in the Association's position. While we have categorically rejected previous attempts to rebasen the system that were driven solely by deficit reduction demands, our current position is based on a recognition that an objective standard is needed for judging whether PPS rates are adequate. Since the Prospective Payment Assessment Commission (ProPAC) and Congress have implicitly relied on hospital operating margins as the standard for judging adequacy, adopting this position would simply make that standard explicit.

Such an approach would also provide hospitals with payment predictability—a fundamental principle that was promised when PPS was instituted—to allow hospital managers to undertake financial planning necessary to operate their institutions efficiently. Because payments to individual hospitals would not be linked to their own costs but to aggregate or systemwide costs, incentives to improve efficiency would be preserved.

Furthermore, to ensure that Medicare payment policy issues are decided on their merits, AHA believes that the program should be exempted and removed from the Gramm-Rudman-Hollings budget deficit measures and removed from the unified budget of the United States.

Equity Improvements

Our equity proposal includes four basic elements:

First, we recommend establishment of a *single base rate,* adjusted for differences in the kinds of patients admitted to hospitals and for differences in the prices hospitals must pay for resources.

However, our support for this approach has two contingencies:

- The single base rate should not be implemented without refined adjustments for patient mix and resource prices that are described below; and
- Movement to a single-rate system must be accompanied by a "hold-harmless" provision that protects hospitals from a reduction in payment resulting from movement to the single rate. In other words, we cannot support efforts to achieve a base rate simply by cutting urban hospital payments to increase rural hospital payments.

Second, the diagnosis-related group (DRG) system has been widely criticized for its failure to capture the "severity" of a patient's condition, and considerable resources have been expended in developing "severity measurement systems" to either replace the DRG system or be used in concert with it. While we believe that a comprehensive severity adjustment should eventually be implemented, none of the current systems has reached a State of development and validation that would warrant its adoption. Until such a system can be embraced, a program of *DRG refinement* should be adopted. Efforts should focus on refinement of "problem" DRGs, which account for more than 1 percent of Medicare admissions and which show substantial variation in costs.

Third, PPS rates are currently adjusted only for differences in prevailing wage levels. In the long term, we believe that a comprehensive adjustment should be developed that accurately reflects prices paid by hospitals in local markets for all types of resources. While such an adjustment or index is being developed, we believe the following steps should be taken in FY 1990, or the short term:

- The *existing wage index should be updated* to reflect current wage levels; and
- An *exceptions or appeals process* should be created to correct problems arising because of inappropriate assignment of a hospital to a local market; errors in data or in calculations; variations in resource prices within a local market that are attributable to government policies or local economic conditions; and variations in resource use that are clearly beyond the control of hospital management and medical staff.

In fact, in both the long and short term, however refined the adjustments for patient mix and resource price, an exceptions or appeals process will always be needed to take into consideration unique circumstances of individual hospitals that cause them not to fit a general rule. All routine adjustments assume that hospitals are "average" and will continue to work well for a majority of hospitals. But some hospitals will simply not fit into such a system of averages.

Fourth, given that small rural hospitals may lack the volume that is essential to a payment system based on averages, *rural hospitals that operate fewer than 50 beds should be given the option to receive cost- based payments.* In addition, criteria should be developed that would permit larger hospitals, including selected urban hospitals that are the sole source of care for their communities, to seek and receive an exemption from PPS. The cost of extending this exemption to rural hospitals is small: rural hospitals operating fewer than 50 beds account for only 2 percent, or about $750 million, of total payments under PPS. Criteria should also be developed to exempt larger hospitals that are the sole source of care for their communities but that do not now qualify as sole community providers.

Finally, the role of hospitals, especially rural hospitals, in meeting the needs of patients for both acute inpatient care and skilled nursing care of limited duration should be recognized by allowing payment for "transitional care" provided in hospital settings. Payment for sub-acute care would both improve the quality of care available to beneficiaries and enable hospitals to make better use of their facilities.

Similarly, existing rural referral centers should continue to receive the urban payment rate. Rural referral centers treat more severely ill patients and receive cases that tend to be more complex than the average rural hospital. In addition, they offer many specialized, high-technology services and procedures that typically are not available in the average rural hospital. Because of their unique services and operational characteristics, rural referral centers' costs are more similar to their urban counterparts.

Changes in Organization and Delivery

The deteriorating financial condition of many of the nation's rural hospitals, combined with the declining occupancy rates for these hospitals, suggests that changes are needed in the way in which care is organized, delivered, and financed. Changes in Medicare payment policies alone are an incomplete response to the challenge of changing patterns of delivery and utilization. While some hospitals may not be needed to provide acute inpatient care, they may still have an important role to play in ensuring access to care for the communities they serve.

Changes in Medicare payment policies alone will not enable these hospitals to make the transition to a new role. The programs approved by Congress to finance demonstration projects on facility conversion and restructuring are an important step in long-term reform of delivery systems. Additional efforts are needed, involving both State and local government and private initiative. State and local government can facilitate this restructuring through regulatory relief and financial and political support. Private initiative is needed to create alliances and affiliations among rural hospitals and between rural hospitals and regional referral centers located in both rural and urban areas. The challenge is to create a hospital and health care system that is responsive to both changing patterns in the delivery of care and local community needs and capabilities.

Enclosures.

RESPONSES TO QUESTIONS SUBMITTED BY SENATOR MITCHELL

Question 1. When you State that 60% of rural hospital are expected to experience an operating deficit in FY 1990, are you referring to an overall hospital operation deficit, or a negative margin on Medicare business?

Question 2. The projected status for FY 1990 that you outline sounds very dismal because you say that it takes into account the changes that Congress recently made to assist rural hospitals. Are these projections based on AMA data or another source of information?

Combined answer for 1 & 2. AMA's projection that more than two-thirds of all hospitals will experience deficits in fiscal year 1990 refers to Medicare margins. The projection is based on Medicare data from the third year of the prospective payment system (PPS) as reflected on the HCFA cost reports. These data are then trended forward according to current law payment policies with adjustments for case mix, the number of cases and other indicators.

Question 3. Do you believe that it is possible to design criteria for hospital viability, such as a minimum threshold of beds or occupancy necessary to keep a hospital operating in the red (sole community providers excepted)? How can we best differentiate essential hospitals from those that could close without harming the community?

Answer. The characteristics that determine a particular hospital's viability vary significantly. Differences in services, payer mix, geography, size and location all contribute in varying degrees to a given hospital's financial picture. For example, size is an indicator of a hospital's viability. A facility only providing acute care to an average daily census of fewer than 10 patients will probably find that fluctuations in severity and number of patients will present staffing and other difficulties that are hard to manage cost efficiently under PPS.

Size is only one indicator. A hospital serving a large population of uninsured patients may not be viable regardless of its census. Similarly, inadequate Medicare and Medicaid reimbursement is another factor forcing hospitals of all sizes into financial trouble.

Furthermore, identifying those hospitals' that could close without harming the community is exceedingly difficult for many of the same reasons. One must examine the extent to which the hospital provides service only to its community and the extent to which the community receives its heath care services solely from the hospital. Although these patterns are very important indicators, they alone will not differentiate essential hospitals. For example, other factors include the impact of a closure on other medical resources in the community—as physicians and other providers often leave with the hospital—and the variety of services other than acute care offered by the hospital.

The unique relationship between a rural hospital and its surrounding community defies the generalizations that would be necessary to make broad policy regarding which hospitals could close without adversely affecting the residents. The important issue is not identifying those hospitals that could close but rather identifying the type of facility that will meet the health care needs of the community. Although we agree that some hospital closures may be necessary, it is inappropriate to suggest that all hospitals not deemed "essential" should, in fact, close. AHA is currently examining the most appropriate methods for reshaping health care delivery in rural areas.

Question 4. I am interested in the use of rural beds for subacute care as you have brought up. What are your suggestions for encouraging greater use of swing beds and other transitional care services in unoccupied acute care beds?

Answer One of the components of AHA's equity plan is to expand the use of swing beds by lifting the bed limitation in current law and by allowing urban hospitals to obtain swing-bed certification. Another way to encourage the enhancement of transitional care services includes an increase in the Federal funds available for rural hospitals that wish to consolidate and/or diversify in this area. In the initial round of grant applications, there were 700 proposals competing for approximately 90 awards under the rural health care transition grant program; clearly the interest and ideas are out there, unfortunately the funding has been limited.

Question 5. The reimbursement changes that you suggest for equity improvements are certainly worth consideration. Do you have any estimates on the cost of your proposals? (e.g., would it add 10% to Part A expenditures; 20%?) What number of small hospitals would you expect to use your option of cost-based reimbursements?

Answer. Based on the cost of moving to a single base rate, AHA's plan to improve the equity of Medicare reimbursement will cost approximately 51 billion. Based on the number of small rural hospitals with negative margins, AHA anticipates that between 50 percent and 75 percent of all eligible hospitals would exercise their option to return to cost-based reimbursement.

Question 6. How many hospitals have such a relatively small number of Medicare patients that even elimination of the rural/urban differential would not bring in sufficient new dollars to take them into the black?

Answer. Approximately 40 percent of all rural hospitals are experiencing Medicare losses in excess of the standardized rate differential, thus eliminating the differential would not be sufficient to ensure a positive Medicare margin. However, establishing a single base rate with adjustments for the kinds of patients admitted to hospitals and for differences in the price of labor would go far toward establishing a fairer payment system.

Eliminating the differential would only achieve this goal, however if it included a "hold harmless provision to protect hospitals from a reduction in payments as a result of the single base rate. It would not be fair to eliminate the differential simply by cutting urban hospital payments to increase rural hospital payments.

RESPONSES TO QUESTIONS SUBMITTED BY SENATOR PRYOR

Question 1. Is there a disproportionate burden of proof for rural America and the rural hospitals vis-a-vis urban American and the urban hospitals in proving a difference cost? The burden of proof issue is one that I think needs to be addressed.

Answer. The existence of an unexplained 11 percent differential in the standardized rate is a hurdle that rural hospitals have to overcome before they can begin to discuss the real issues which demonstrate that their costs in some instances are at least as high as their urban counterparts. For example, shortages of health care professionals in many areas have forced rural providers into the urban marketplace. In some instances, rural providers must pay a premium to attract physicians and nurses away from the cities. AHA supports updating the area wage index on an annual basis to reflect these trends.

Rural hospitals often pay as much, if not more, than urban hospitals for supplies, drugs and services such as repairs. Although many rural providers have entered into group purchasing arrangements to help lower the cost of supplies through increased volume, the groups will still pay at least as much as an urban provider. Furthermore, repair technicians who must travel greater distances to service hospital equipment in rural areas will often charge more because of the travel time.

Question 2. Is 1994 a proper time, is it an adequate time, for us to phase in this legislation that we are considering at this time, or is it too late, or what is going to happen in the meantime?

Answer. Given the severe financial difficulties facing most rural hospitals today, AHA advocates moving quickly toward a fairer reimbursement system that would ensure adequate and equitable payment for all hospitals. To accomplish this, the standardized rate must be recalculated and a single base rate must be established, thereby eliminating the urban/rural differential. The crisis in the American health care system needs to be addressed immediately; five years may be too late.

Question 3. If we do nothing, if we absolutely do nothing about this formula, where we will be in rural health care in the United States say in the next five years?

Answer. Absent constructive changes in the health care delivery systems in rural America and without positive restructuring of the payment system, we will see many more *inappropriate* rural hospital closures in the next five years and access will be compromised. More than 60 percent of rural hospitals have negative Medicare margins; many of them have operated in the red for a number of years. These hospitals are not unlike other business in that they cannot survive for very long with such deficits. Though some closures may be appropriate, steps must be taken to ensure that access to basic health care services are maintained. Consolidation and the transition to alternative care delivery systems—such as outpatient and nursing care and ambulatory surgery—will take careful planning and additional resources. As long as the payment system is inadequate, rural hospitals will not have the resources to explore other options.

Responses to a Request for Comment by Senator Rockefeller

[During the Senate Finance Committee's rural hospital hearing on May 4, 1989, you asked me to comment on ProPAC's survey of closed hospitals which reports that many rural hospital administrators said that Medicare had nothing to do with their closure. I hope this will expand upon the response I offered at the hearing.]

Hospitals close for many reasons and it is difficult to disentangle the many interacting causes of hospital closure. However, after examining a number of different causes, Medicare is often the common denominator. First, the ProPAC study does show that Medicare operating margins of hospitals that closed were, on average, lower than those of hospitals that did not close. Clearly, Medicare contributed to the fiscal pressures that lead to closure.

Second, the immediate cause of closure, particularly in rural hospitals, is frequently the inability of a hospital to recruit medical staff to replace physicians who are retiring or relocating. Physicians may be reluctant to locate in a community if the hospital lacks State-of-the-art technology, which may be the case if the hospital's financial position has been precarious for many years. Similarly, inadequate payment may prevent the hospital from recruiting needed staff by making it impossible to offer competitive wages. Of course, financial pressures are not the *only* reason a hospital may be unable to recruit physicians or hospital staff but it is often an important contributing factor.

AHA "data" on hospital closures are a by-product of our efforts to maintain a complete inventory of hospitals. While we do collect anecdotal information on the reasons for closure, the annual survey is of limited use because a hospital's reporting of financial information is often sporadic, at best, during the years immediately preceding closure. In light of the high degree of interest expressed in closures, we plan to institute a more systematic method of collecting data on reasons for, and consequences of, hospital closure.

RESPONSES TO QUESTIONS FROM SENATOR HEINZ

Question 1. Your own studies indicate the smaller the hospital, the lower the occupancy rate—and the deeper the financial trouble. You cite that hospitals with fewer than 25 beds have occupancy rates of some 31%.

How can we expect hospitals with such a restricted financial base to be able to provide even the minimum range of services and quality of services associated with a hospital?

Answer. Even small hospitals with low occupancy rates can continue to provide quality general acute medical care. Most small rural hospitals do not offer highly technical, complex services such as transplants and other relatively rare procedures. Instead, they offer medical management, pharmacology, emergency attention and more routine treatments. Clearly, however, the ability to offer even the most basic health care services is jeopardized when operating margins continue to decline to the point at which a hospital is forced to close its doors or significantly reduce services.

Question 2. You propose to allow hospitals with fewer than 50 beds to return to the cost-based system DRGs replaced in order to remove incentives for unnecessary and long stays.

How would we prevent the resurgence of all the problems associated with cost-based reimbursement, especially with hospitals with depressed occupancy rates?

Answer. Because PPS is based on averages and the law of large numbers, even the most efficient rural hospitals cannot take advantage of the incentives built into the system. Although returning to cost-based reimbursement for small rural hospitals would remove some of the incentives to conserve resources, such a change is unlikely to alter the behavior of individual hospitals. The proposal is intended to provide fair payments to hospitals, not promote unnecessary and long stays. Peer Review Organizations, State licensure and the Joint Commission on Accreditation of Healthcare Organizations, will continue to ensure the delivery of quality, cost effective care. Furthermore, because Medicare is only one payer and because the hospitals eligible for cost-based reimbursement already have a restricted range of services, a relatively low cost basis, and low volume, there would be little incentive to abuse such a payment system.

Question 3. What, other than financial solutions, does AHA see as the way to preserving our rural hospital system? What are some of the more innovative approaches you've seen among your members?

Answer. The health care delivery systems in rural areas must adapt to the changes in rural communities. In some instances this change may be the consolidation of services where the hospital becomes the focal point of all health care related activities in the community—nutrition programs, home health care, nursing care—in addition to acute care. In other instances, perhaps due to the proximity of other more up-to-date facilities nearby, the local hospital might best be used as an emergency center and/or nursing home. Increasing the use of swing beds and outpatient services are two other options. The consolidation and/or closure of some hospitals should not be forced on a community as a result of an inadequate payment system; these changes must be planned and implemented very carefully so that access to health care is not jeopardized.

Although a number of hospitals have begun to make changes in their delivery of health care, many more find the task prohibitively expensive. The overwhelming response to the initial round of the rural health care transition grant program demonstrates that rural hospitals are interested in making the necessary adaptations but lack sufficient resources. Strategies to ensure access in rural areas vary according to community needs and resources. Rural hospitals have responded to their changing environment with some innovative approaches:

- Consolidating inpatient services, striving to use existing resources more effectively (using multi-skilled personnel), using fewer beds and converting existing resources to other levels of care, thereby further reducing personnel. The Montana Hospital Association has just received a grant from HCFA to pilot test a new category of health facility called a medical assistance facility. While providing a level of care less than a hospital, this type of facility will be a real alternative to frontier hospitals faced with closure.
- Establishing periodic specialty clinics in such areas as orthopedics, cardiology, otolaryngology, and opthalmology.
- Diversifying revenue and services along the health care continuum: swing beds, other long-term care; outpatient care; home health care; day care; wellness, screening and education; transportation services; and supervised independent living for the elderly. For example, two hospitals in North Dakota joined forces to convert one

into a nursing home and improve the services offers by the other. Similarly, a hospital in Minnesota downsized its acute care facility to allow for more nursing home beds and added a group of living-assisted apartments.

- Changing the mission and business focus of the hospital into the hub of health care and social services in the community.

RESPONSE TO A QUESTION SUBMITTED BY SENATOR SYMMS

Question. What would you suggest as the best way to deal with the reimbursement inequity between urban and rural hospitals? Do you think that Congress should adjust the differential, giving hospitals more and urban hospitals less? *or* should Congress use funds from Medicare Part A's trust fund, requiring more from the budget, and if so, what other area of the budget should we take it from?

Answer. As AHA's proposal States, the way to ensure that Medicare payments are both adequate and equitable for all hospitals is to recalculate the standardized rate and move to a single base rate—thereby eliminating the urban/rural differential. Automatic annual updates, refinement of certain DRGs and a more accurate area wage index are the other vital components of the package. Additional funds needed to achieve a fair payment system should come from an increase in the Hospital Insurance portion of the Social Security (FICA) payroll tax. Without this increase, additional funds to eliminate the differential should come from the Hospital Insurance trust fund, because the HI trust fund is currently solvent. Any effort to address the rural hospital payment inequity by reducing payment to the urban hospitals would only perpetuate PPS's overall payment inequities.

PREPARED STATEMENT OF TIM SIZE

My name is Tim Size, Executive Director of the Rural Wisconsin Hospital Cooperative and for the last 4 years, Hospital Constituency Director of the National Rural Health Association. The National Rural Health Association is a broad-based organization representing a diverse membership, including hospitals, community and migrant health centers, nursing homes, universities and others, as well as private doctors, nurses, educators and researchers—all working together toward the common goal of improving rural health and rural health care. The Rural Wisconsin Hospital Cooperative is owned and operated by 20 hospitals in southern and central Wisconsin in order to promote and implement improved rural health services. The Cooperative, started in 1979, is one of the country's first and most developed rural hospital networks. appreciate the opportunity to testify on behalf of NRHA members and the Cooperative on the current status of rural hospitals.

RURAL COMMUNITIES AND HOSPITALS FACE COMPLEX CHALLENGES

Rural America is a place of great variety. Rural communities, like the hospitals that serve them, vary greatly. Rural Georgia is quite different from rural Wisconsin, and its hospitals usually reflect those differences. Despite their differences, many, if not most rural areas share a set of common problems, including:

- inequitable physician and hospital reimbursement;
- higher unemployment and lower family incomes;
- fewer insured people and lesser ability to pay health care bills;
- declining populations as rural people move to cities;
- a shrinking tax base with an increasing demand for tax funding;
- perhaps due to the above, more stress-related health problems.

A variety of shifting health care system forces combined with weak rural economies combine to place many rural hospitals in jeopardy. At the current rate of more than 40 rural hospital closures per year, well over 400 or 15 percent of the nation's more than 2,600 rural hospitals will close in the next ten years. Recognizing that the annual number of closures has increased annually during the 1980s, the Senate Special Committee on Aging recently cited the projection that as many as 600 rural hospitals may close during this time period.

Obviously, not all closures have bad outcomes for rural health or the rural economy. Many closures, however, seriously compromise the health care access of Medicare beneficiaries and other rural residents who have no other place to go for service that is within reasonable driving time. The closure question is not will rural hospitals close, or even, should hospitals close? The questions is more appropriately are the "right" hospitals closing and how is the decision being made? Will there be a net benefit or cost to the local community as a result of the closure? Unfortunately, rural hospital closures are too often the result of bad luck or inadequate investment rather than lack of need—the health care and economic outcomes are almost entirely ignored, except by the rural communities themselves.

GOVERNMENT'S ROLE

Over recent years it has become fashionable "to blame the victim" of systemic social and economic forces—unemployed workers, the homeless, kids dropping out of school. It makes those of us who are doing okay feel better about ourselves—our own ability to be clever, to compete, to prosper. It is an attitude that protects us from fear—the fear based on that inner knowledge that our systems are fragile and that shifts in policy or chance can radically change any of our lives.

- **Multiple Problems Cover Up Government Inaction.** While it is true that rural hospitals and rural communities do face a number of problems, discriminatorily low Medicare reimbursement is an issue for which the Federal government is unquestionably responsible. Because my son is not yet spending enough time on his homework, I don't refuse to fix his broken leg. I certainly don't justify breaking the other leg saying, well one's already broken. The same is true for rural hospitals. We simply cannot ignore that under PPS, urban hospitals are reimbursed an average of about 36 percent more than rural hospitals for the same service. Rural hospitals are the low-cost alternative, but not that much lower.
- **Declines in the Volume of Inpatient Services** in rural hospitals have begun to change the emphasis for many hospitals from inpatient to outpatient. Rural hospitals have experienced declines in admissions. For some rural hospitals, this change has reduced their inpatient volume to below the critical numbers needed to sustain some inpatient services. It is ironic that the hospitals that most need to change are often the ones that have the fewest human and financial resources to plan and implement such changes—the Rural Health Care Transition Grant Program is meant to address this problem but only a small fraction of eligible hospitals will be helped with the current allocation.
- **Health Personnel Shortages** continue to plague rural America. Most rural health care providers indicate that recruiting is harder today than it was five years ago. Recruiting problems exist especially for family doctors, nurses and all types of therapists. The supply of critical personnel is simply too small to meet the increasing demand at both rural and urban facilities. Because supply is short, competition for health personnel is increasing. Underpaid rural facilities are having a difficult time competing with other types of facilities and programs that have more resources, and in some cases, more desirable locations.
- **Lack of Access to Affordable Capital** is an increasing problem. Rural facilities built under the Hill-Burton Program in the 1950s and 1960s are aging and need to be replaced or remodeled. Rural hospitals are in weak financial condition due to all of the above problems; their building or remodeling programs often are not considered very good investments in the now nationalized capital markets. Rural people, like their urban counterparts, want attractive new facilities with the most modern equipment, and they will often drive past their rural hospital to get the amenities that they associate—rightly or wrongly—with quality care.

SIMILARITIES WITH INNER CITY URBAN HOSPITALS WHO NEED AND RECEIVE HELP

Inner city and rural hospitals are both frequently subject to simplistic stereotypes—just as was mentioned earlier for rural hospitals, inner city hospitals also have many differences among them. However there are a number of important generalizations that can be noted about rural and inner city hospitals—less of an "odd couple" than many would think. The health care environment rural hospitals face is very similar to that previously used to support special assistance to teaching hospitals and hospitals with a disproportionate share of Medical Assistance patients:

- Inner city and rural hospitals both lack the resources needed to help them adapt to a radically changing environment.
- Inner city and rural hospitals have high proportions of uncompensated care reflecting the relative weakness of the economies in the two areas.
- Inner city and rural hospitals have small private pay bases on which to shift the cost of care for the poor.
- Inner city and rural hospitals rely heavily on public payors—Medicare and Medicaid—for their revenues, and both programs are under major budget pressure to pay less than cost. Combined they account for 50 percent or more of these hospitals' revenue.
- Inner city and rural hospitals have similar difficulties in attracting health professionals.

- Inner city and rural hospitals are the sole community health resource for the populations they serve. If they close or curtail services, their populations are left without access.

WHAT CHALLENGES ARE UNIQUE TO RURAL HOSPITALS?

While there are many similarities between inner city urban and rural hospitals, there are also some important differences:

- **Federal Reimbursement Favors Urban Economies**—Rural hospitals and physicians are penalized for being "inefficient" because they work on a smaller scale in geographically less populated areas; at the same time they are denied the advantage of some lower input costs through deductions in Federal reimbursement formulas. The reverse is true for urban providers; Federal reimbursement formulas allows them to maintain the benefit of economies of scale while protecting them from the higher input costs.
- **The High Cost of Maintaining Critical Access**—The sparse populations in rural communities result in higher standby costs for low volume services in rural hospitals, even if the service is as essenial as emergency services.
- **Change Hits Hard**—Rural hospitals' heavy reliance on Medicare as a payor makes them disproportionately vulnerable to changes in the Federal program. Every ripple in the Medicare program causes a wave in the rural hospital that makes for a very rough ride.
- **Ambulatory Care is a Way of Life**—One of the ways rural hospitals have coped with the changes brought about by PPS and by declining inpatient volume has been to develop more ambulatory services. It is not at all unusual for rural hospitals to have 40 percent or more of their total revenues coming from ambulatory services. These ambulatory services are going to be greatly affected by paying for them prospectively, and I would urge your close attention to that impact. Many rural hospitals are predicting that this change could be the one that will halt more services than any of the Medicare changes to date.
- **Generalist Personnel Needed**—Rural hospitals and other rural facilities have different personnel needs than larger facilities. There is a greater need for well-trained generalists in both nursing and medicine. Because of their low volumes, rural hospitals often require more part—time personnel and where available, multi-competency personnel play a vital role in efficiency.
- **The Low-cost/Low-tech Alternative**—Rural hospitals are the low- cost, low-tech alternative to high-cost, high-tech care in the cities. We should be careful not to dispose of this alternative until we know what the relative efficacy of each alternative. Perhaps PPOs should be developed that encourage urban dwellers to seek care in less costly rural facilities.

Differences in operating systems can be either assets or liabilities. Unfortunately, in the current environment much of the uniqueness of rural hospitals tends to show up on the wrong side of the ledger. This condition could be helped by recognizing that rural hospitals are not downsized urban models. Rural hospitals and the populations they serve have unique essential characteristics that require different and more flexible approaches.

HOW ARE RURAL HOSPITALS RESPONDING?

Many rural hospitals are adapting to the unprecedented changes of the last five years despite the many problems facing them:

- **Rural Hospitals are Diversifying** into new product lines more relevant to today's new service demands. These new services both increase access and provide a way for hospitals to spread their fixed costs.
- **Rural Hospitals are Networking** for quality and efficiency along a continuum of affiliations that range from loose referral networks to cooperatives to managed systems. These networks are both rural-to-rural and rural-to-urban.
- **Rural Hospitals are Developing Systems of Care** at the local level, integrating the various elements of the health care system in their communities. These relationships between doctors, hospitals, public health, long-term care, etc., are made to assure the survival of access points to care and to improve the coordination of services and to end fragmentation.
- **Rural Hospitals are Becoming Less Dependent on Inpatient Revenue** to adjust to inpatient volume declines and their inability to cover inpatient costs.
- **Rural Hospitals are Developing Alternative Models** of care and are remaining as community health facilities in areas that can no longer support an inpatient

service. These are evident in newly emerging formal experiments in Montana, California, Colorado and Arkansas.

WHAT ELSE NEEDS TO BE DONE?

Health reimbursement policy should encourage rural hospitals to "do the right thing." We need a public policy that is both consistent and flexible, and that will:

- **Pay All Hospitals & Physicians Adequately and Equitably** regardless of their geographic location. If the current Prospective Payment System does not work for a class of hospital it should be modified or replaced before it forces the unplanned closure of hundreds of facilities. Outpatient services should be paid at cost until the impact of including them under a fee schedule is fully understood.
- **Develop Increased Local Access** to locally-appropriate and necessary services. Services follow payment. Pay well for organ transplants and organ transplant services will proliferate. Pay well for coordinated, cost effective rural health care and those services will follow, as well. Expand the funding available for rural hospital transition grants.
- **Create Immediate Loan Forgiveness Programs**—we can no longer penalize young people for choosing to locate in rural communities—their significant college debt prohibits this as a practical option.
- **Provide Loan Guarantees For Appropriate Capital Needs** to bridge the gap between local rural communities and the national capital markets that now dominate the hospital Industry.
- **Require State and Federal Regulations** to "make sense" in rural settings—we can have regulations that provide equal protection to the patient while not assuming that all urban models are most appropriate in rural communities.
- **Encourage New Rural Health Care Model Development** that does not depend on a high volume of inpatient care for survival and that provides an option for rural hospitals no longer able to sustain, under the best of conditions, an inpatient service.
- **Find Ways to Keep Medicare Part A dollars in Rural Communities** to support other vital health services in the event a hospital does close.

The National Rural Health Association and the Rural Wisconsin Hospital Cooperative are committed to continuing to work toward the public and private partnership required to implement these necessary changes. Thank you for the opportunity to testify and especially for your critical interest and support.

Enclosures.

RESPONSES TO QUESTIONS SUBMITTED BY SENATOR HEINZ

Question 1. Mr. Size's testimony suggests that we relax State and Federal regulations for rural hospitals. On the one hand, it hardly seems reasonable to require a full time social worker, for example, on hand in one of our 25 bed hospitals in Pennsylvania.

Where would you draw the regulatory line and how wouldn't we run the risk of setting up a 2-tiered system of quality care for urban and rural patients?

Answer. We now have a 2-tiered system of access to quality care by preventing services from being delivered due to a rigidity in our application of regulations written for the ideal 400 bed suburban hospital. The challenge is to develop a workable regulatory system that assures a reasonable standard of quality and access in a number of very different community and service environments. This means exploring flexibility in "process" standards while even becoming more rigorous about "outcome" standards. This is not easy but it can and must be done.

Question 2. There are multiple external pressures beyond Medicare that impose financial hardship on hospitals—such as the high- cost of medical technology, staff shortages, greater use of outpatient services, out-migration.

How can we be assured that adjustments in rural payment rates alone will mitigate these other forces beyond Government control?

Answer. You can't and they won't. As I mentioned in my testimony, rural communities are not stuck waiting and moaning for the Federal Government to end its discriminatory payment policies. In fact, I believe we are leading the industry in responding to and creating change—the necessity of our multiple problems has required us to do so. The issue here is how many hospitals will be buried that otherwise would have survived. Rural payment equity is not enough to insure survival but inequity is enough to insure closure.

Question 3. Most medical education in this country is conducted in medical schools located in metropolitan areas—despite the fact that the health needs of rural and urban communities vary considerably.

How might we involve rural hospitals more in medical education? How might we better train emerging physicians and other providers in the unique needs of rural populations and create incentives to ensure an adequate and highly trained supply of physicians in rural areas?

Answer. Rural hospitals have traditionally understood the value of affiliation with medical school, nursing school and other health training and research programs. But we face traditional elitist attitudes in many university centers that "bigger is better" and that tertiary medicine is more interesting than primary. In our country, you get what you pay for; pay rural physicians fairly, let alone an incentive and you will have more demand for rural practices; require schools to diversify their training in order to access Federal funds and they will do so.

Question 4. What has been the public's response to the innovative steps that frontier, transitional grant, and other hospitals have taken in rural communities? Has there been a loss of trust or any change in patient referrals for care?

What outcome or trend data do we have to indicate whether the quality, level, or outcome of patient care has changed for the residents of the communities involved?

Answer. The Rural Wisconsin Hospital Cooperative and most of its member hospitals have been fortunate to have implemented a number of innovative steps over the last 10 years. And during that time we have seen our market share stabilize—a tangible sign of having our communities' trust. But this has not been imposed top—this has been change and innovation nurtured by and from the local community and networking among rural communities.

Responses to Questions Submitted by Senator Mitchell

Question 1. Do you believe that it is possible to design a reimbursement system that will discriminate between those small hospitals which, by all standards, should close, and those that are essential to the community?

Answer. No, the closure of a hospital for quality reasons can not and should not be done by a reimbursement system—the issue of insuring quality is the job of Professional Review Organizations. To do otherwise buys into a perspective that we know now and will always know in the future what a specific hospital service should look like in every county of the country.

The fundamental strength of our health care system, not withstanding its many problems, is its flexibility to adapt to a continuously changing environment and local expectations. We need to enhance our capabilities to describe outcomes, and to make judgements based on those outcomes. We do not need arbitrary or uniform rules—health care and our country is too diverse for such an appealing or simple minded approach. What all of us want from health care does not need and will be strangled by a 35 mile rule or any other like simplification.

Question 2. Would you expand a bit on your Statement that we should encourage new rural health care models that don't depend upon a high volume of inpatient care? This makes intuitive sense for even larger hospitals. Do you have some specific ideas that you could share with us?

Answer. First, let me emphasize that the promotion of new models less dependent on inpatient care is not to say that this should be the only or even major type of model for rural hospitals—there is a lot good about the current evolving traditional model of rural hospitals that must not be lost in a search for silver bullets or visionaries. Next, I would refer you to a number of suggestions made by Steven Rosenberg in a policy paper recently prepared for the National Rural Health Association:

(a) Create a new Medicare benefit similar to the Medical Assistance Facility currently being researched in Montana BUT recognize that this is not meant as a model that would be appropriate to most or even many communities. It is one of many alternatives that needs to be developed.

(b) Enhance the Rural Hospital Transition Grants program.

(c) Create a targeted category of rural providers whose survival is absolutely essential but not in a manner that penalizes rural hospitals that are not deemed "essential."

(d) Require the Health Care Financing Administration to grant waivers to several States to facilitate the development of different kinds of alternative rural facilities.

Responses to Questions Submitted by Senator Pryor

Question 1. Is there a disproportionate burden of proof for rural America and the rural hospitals vis-a-vis urban America and the urban hospitals in proving a difference in cost?

Answer. The weight of the status quo, the inertia of the Health Care Financing Administration and the relative wealth of urban hospitals all stand against a handful of rural voices. Even today, we still struggle with a continual series of misStatements (some deliberate—some inadvertent) about the size of the urban rural differential. The difference in the national standardized payment amounts is about 12% but the actual difference including wage index adjustments continues to be well over 30%.

I do not doubt the mathematical integrity of HCFA's cost numbers, only their relevance. Urban hospitals, as a group, made substantial profits on the Medicare in the first 3 to 4 year of the Prospective Payment System—a time when rural hospitals were struggling to break even. Looking at the costs during this period only tells you the obvious, people with money to spend generally spend it; those without, can't spend what they don't have.

The current reimbursement system totally ignores the coming together of standards and expectations by rural and urban systems of care—whatever validity existed for past cost differences per DRG, belongs to the past.

Question 2. Is 1994 a proper time, is it an adequate time, for us to phase in this legislation that we are considering at this time, or is it too late, or what is going to happen in the meantime?

Answer. The government is accustomed to taking years to address major social problems with multiple causes, but payment equity is not an issue of complex social change. It is an issue of pay discrimination by the Federal Government for services rendered, *the results of which* is creating significant social problems and hardship. This is not an issue of how quick the government can provide assistance but how quickly it must stop doing injury.

Question 3. If we do nothing, if we absolutely do nothing about this formula, where will we be in rural health in the United States say in the next five years?

Answer. The average rural hospital is now losing money after many years of already paring down budgets to stay ahead of federally imposed payment inequities. The fat is well gone. With or without change, you will see an increasing escalation of the rate of closures, some appropriate, many not. The issue is now damage control, not problem avoidance.

COMMUNICATIONS

STATEMENT OF THE AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE

STATEMENT OF THE PROBLEM AND CURRENT STATUS

More than one-fourth of the U.S. population—over sixty million people—live in rural areas. In addition, over 25% of this nation's children under eighteen and nearly one-third of senior citizens (twice the national rate) are rural residents. It should also be noted that the number of individuals over 65 will increase from 25 million to about 65 million in the next 40 years, with many of them expected to locate in rural areas. It is these two demographic groups that require the highest levels of care, but who are not receiving appropriate access to health care services.

In many parts of this country, particularly in the South, West, and Midwest, there are entire counties without physicians. Federal and State facilities still are chronically understaffed. Further, there are other counties and communities that have only one or a couple of physicians to meet the needs of large areas. The National Health Service Corps (NHSC) Scholarship Program, over the last 15 years, and, until recently, has provided a cadre of skilled physicians for rural (and urban) underserved areas. No new scholarships will be awarded this year. These communities are already finding it difficult to attract physicians because the number of prior scholarship recipients, who had previously staffed many of their communities and facilities, has already dropped from 1,400 in 1985 to about 220 in 1989. The replacement mechanism is the NHSC Loan Repayment Program, which was just authorized and funded last year. Progress has been slow due to initial start-up requirements and in locating willing physicians. There also is no assurance that communities that once had an NHSC physician will find one immediately or any time soon after a prior scholarship recipient leaves.

The majority of communities that had received NHSC scholarship obligees are not able to attract physicians because they are not competitive. The absence of the scholarship program forced many rural, migrant, and community health centers to trying to enter the competitive market. Although some were successful, the vast majority of those serving the poor or very low concentration populations have not been.

The 357 rural Community Health Centers and the 117 Migrant Health Centers provide essential primary care services for the poor and non-poor in a large percentage of rural communities. However, funding has not been maintained at current service levels. In addition, these centers have seen significant increases in the numbers of uninsured patients and in malpractice premiums, causing obstetrical services to be eliminated in many of them.

Despite major increases in the number of rural physicians between 1970 and 1978, equal rates of increase in rural and urban physicians have not altered the disparity in physician-to-population ratios between rural and urban areas. The ratio of physician-to-population in urban areas remains at 2.3 times the rural ratio. Although increasing numbers of practitioners are locating in rural areas, market forces (so-called "diffusion") have not led to an adequate level of physicians to the smaller, more isolated rural counties (less than 10,000 population), and are unlikely to do so under current trends and Federal and State funding of programs. The disparity in physician-to-population ratios between the small (e.g., >10,000 population) counties and the U.S. in the aggregate actually has been *increasing* over time, even though overall physician supply and availability grew in *both areas*.

Recent data from David A. Kindig, M.D., Ph.D., in a study supported by HHS and done at the University of Wisconsin (Madison) for the National Rural Health Association, accurately chronicles the significant contributions of D.O.s in small, rural, isolated communities in various regions of the U.S. of the 32 States studied by Kindig, D.O.s represented only 5.1% of all physicians (M.D. and D.O.), but they accounted for 15.3% of all physicians in population areas of 10,000 or less. This finding reaffirms the contributions of D.O.s in these very small areas, and the need to build upon the training models and outreach programs leading to such concentrations of D.O.s in underserved areas, such as those in place at colleges of osteopathic medicine.

Physician growth in these small rural counties has been less than one-third that of all other non-metropolitan counties. As of last year, the Department of Health and Human Services had designated nearly 2,000 primary care health manpower shortage areas (HMSAs), of which almost 1,300 were located in rural areas. Despite the increase in the total number of rural physicians, the number of rural HMSAs has not changed. As many as 25 percent of rural physicians may retire or leave their communities in the next five years.

The problems confronting rural America in meeting its diverse health care needs require a variety of approaches. Much needed attention is being focused by the Congress on the unique challenges facing *rural hospitals* in attempting to correct imbalances in payments, decreasing volume, and the unattractiveness to physicians, nurses, and others of locating in isolated rural counties. Equally severe, however, is the need to forcefully address the seemingly indigenous problem of recruiting, training, and retaining adequate numbers of physicians and other health professionals to serve in rural hospitals and clinics and to establish practices in these communities. A strong and continuing Federal understanding of the issue is required to target needed resources in programs that have worked and others that show promise.

BACKGROUND ON OSTEOPATHIC MEDICAL EDUCATION

Graduates of osteopathic medical colleges study four years after college to receive the D.O. (Doctor of Osteopathy) degree. D.O.s and M.D.s alike are fully licensed physicians under all State licensing laws which assures full rights to use all diagnostic and therapeutic techniques including drugs and operative surgery, for the prevention and treatment of human illness.

D.O.s are trained to discern *cause* of disease and not to treat simply the *symptoms*. They teach their patients about personal responsibility for health care management, with particular attention placed on health promotion and preventive medicine. Osteopathic physicians place special emphasis on treating the entire person and recognize the importance of the musculoskeletal system in the proper function of all the body systems. Because sixty (60) percent of the entire body mass is made up of the musculoskeletal system, the osteopathic physician's attention to this system is crucial to appropriate medical diagnosis and treatment.

An important dimension of osteopathic medical care is "osteopathic manipulative therapy," a procedure designed to correct musculoskeletal disorders, thereby helping to restore normal functioning of other body systems. If this form of osteopathic medical treatment is indicated, the osteopathic physician manually moves and adjusts affected portions of the patient's body in order to help restore structure and/or function. This, however, is *only one* medical procedure, and thus only one part of a D.O.'s comprehensive service as a complete physician.

A majority of all osteopathic physicians are in primary care practice. Major traditions of osteopathic medicine from its founding in 1874 have been to meet the needs of rural America and the elderly, through decentralized education and clinical training. Two-thirds (66%) of all D.O.s practice in communities smaller than 50,000 population.

However, indebtedness of osteopathic medical students is increasing and averaged $65,000 at graduation in 1988. With primary care practice not being reimbursed equitably by third party payers, adequate incentives such as loan repayment, restoration of deductibility of student loan interest, and enhanced equity in Federal and State medical program reimbursement, must occur promptly to ensure appropriate access of health care and recruitment and retention of committed physicians in rural areas.

Over the last twenty years, the number of colleges of osteopathic medicine has tripled from five to fifteen, and the number of graduates has quadrupled. They have continued their primary care emphasis and practice location in small rural counties and towns. Despite the fact that only about five percent of this country's physicians are D.O.s, they provide 15-20 percent of U.S. primary care medicine. Since osteopathic medical graduates now represent 9% of the total medical school graduates, some improvement is expected. Osteopathic medicine is the fastest growing health profession, but to take advantage of this growth and the performance in meeting underserved medical care needs, the Federal partnership must continue.

Federal support has been particularly beneficial to colleges of osteopathic medicine in meeting the costs of expanding primary care medical training capacity expansion, consistent with Federally-identified shortages. This support has been critical due to lack of alternative sources of support for development of this type of training capacity.

Osteopathic medical education cannot do it all with the existing funding and the small numbers of our schools and graduates relative to the problem. However, we continue to make progress, but will need to continue our partnership with the Federal government. Particularly discouraging is the Administration's request for no continued funding for highly targeted, cost-effective programs that clearly have demonstrated their ability to increase physician retention in small rural communities. These areas are subjects of this white paper.

RURAL HEALTH PROGRAMS AT COLLEGES OF OSTEOPATHIC MEDICINE

Colleges of osteopathic medicine realize it is the identification of individuals with the basic ability to learn and experience the psychic and professional rewards of meeting the comprehensive medical and social needs of these populations that is essential to the ultimate placement and retention of comprehensive, primary care physicians in rural and other underserved areas. Students at colleges of osteopathic medicine receive significant academic exposure to comprehensive primary care medicine. A majority of them serve clinical rotations in rural areas or facilities. Because the elderly population in rural areas is twice the national average, this important and growing geriatric segment of the population receives considerable attention. This training and exposure is a critical factor in the learning process of young osteopathic medical students and continues throughout their professional careers. It is this commitment that has translated into such large numbers of their graduates choosing to practice primary care medicine in rural areas, particularly in smaller, rural areas, and to agree to serve with the National Health Service Corps and in other public service settings.

All osteopathic medical students receive academic exposure to rural medicine and geriatrics. Students across the fifteen colleges of osteopathic medicine serve in a variety of settings such as Federal, State, local, and medical school rural health clinics, community, migrant, and mental health centers, rural physicians' offices, and rural hospitals. These rural clinical rotations are enhanced with significant outreach programs, such as mobile vans and rural satellite clinics. Within colleges of osteopathic medicine, there is a broad array of unique and successful programs specifically targeted to rural medicine. Below is a sample of the activities:

Beginning with the establishment of the first rural clinics in Novinger and Greentop, Missouri in 1928, the *Kirksville College of Osteopathic Medicine* (KCOM) in Kirksville, Missouri, was among the earliest medical schools in the nation to attempt to systematically meet the health care needs of large rural geographic areas while simultaneously providing clinical training for medical students.

The emphasis at KCOM is on producing family physicians. At least 60 percent of its graduates enter that type of practice. A majority, 64 percent, of these physicians go into practice in rural areas and small towns. The KCOM Rural Clinic Program provides an opportunity for senior students, rotating interns, and primary care residents to gain practical experience in a rural setting. Nine osteopathic family health clinics attempt to meet the health care needs of the rural community, while simultaneously providing clinical training for medical students. These clinics are the centers for primary care and allow for the practice of preventive medicine programs. Additional funding would allow KCOM to expand its efforts, alter its sliding scale, and significantly increase the numbers of desperately needy adults and children being served.

KCOM, in late 1988, instituted a loan forgiveness program for third and fourth year students who agree to set up practices in medically underserved rural communities with populations of approximately 25,000 or less. The program is endowed by funds established by two KCOM graduates and friends of graduates. Each year six to eight KCOM students, who are willing to sign a contract to serve in small two settings, will be given the opportunity to participate in this loan forgiveness program.

As an articulated program of KCOM, the Committee for Rural America originally was organized in Kirksville by concerned citizens of northeast Missouri. Among the present purposes of the committee is the operation of a rural crisis center to increase, enhance, and promote awareness of the current economic and stress crises facing families and rural communities, and to coordinate area resources to meet the identified needs of farm and rural families.

With the emphasis on rural health care, special attention is given to the problems of the aging, which constitute a large segment of the rural population. KCOM has established a Center for Aging Population Studies (CAPS) in the rural areas of northeast Missouri. Students working with rural area preceptors and the CAPS program gain valuable clinical experience in health care for the aged.

KCOM's overall rural and primary care commitment and performance were instrumental in the recent establishment of a Federal Area Health Education Center (AHEC) program at KCOM. Beyond the obvious relationship between the rural clinic program and ultimate general practice choice, KCOM attributes much of its success to the students' living in a small town and discovering its attractions, the relatively small but dedicated faculty, and the rural clinic exposure to people and the independent/interdependent rural way of life.

The *West Virginia School of Osteopathic Medicine* (Lewisburg), with its population of 5,000, holds the distinction of being the nation's most rural medical college community. This setting provides the school with its unique focus on and commitment to rural primary health care, and mirrors the findings of special studies of regional rural health needs, especially the needs of rural Appalachia. While the school's programs prepare students fully for practice in any clinical setting, rural family health care is emphasized throughout the four year curriculum. WVSOM's "Pathway to Primary Care" begins with its students, who are chosen for their commitment to an osteopathic medical career in Appalachia long before they apply. Well-developed recruitment and osteopathic medical awareness programs reach into high schools and colleges. Education programs in Appalachian health issues begin in the first year of medical school, with occupational medicine stressing the unique health care needs of the coal and other Appalachian industries. In addition, courses in preventive medicine, geriatric health care, and rural medicine further prepare the students to meet unique regional health care needs. To the extent possible, students are trained in the region in which they are expected to eventually practice. Much training is done in rural Appalachian communities where students learn from small town family practitioner preceptors.

About 75 percent of WVSOM's graduates now practicing in West Virginia are in the State's smallest communities, with populations under 10,000. A remarkable 95 percent are in primary care. WVSOM continues to seek new and innovative ways to help place and keep its graduates in rural practices. It is one of the few medical schools in the U.S. with a physician matching and placement program. WVSOM provides all graduates with profiles of West Virginia communities which are recruiting physicians. The program matches personal and family preferences with professional opportunities, including debt reduction/loan repayment arrangements to encourage service in physician shortage areas.

Through a growing office management program, WVSOM prepares students for the challenges of rural office establishment and also offers business management programs to graduates. In recognition that professional isolation may be the most difficult aspect of rural practice, and that rural physicians often fear that new developments in modern technology may escape their attention, WVSOM maintains a professional enrichment program. It believes that it is one of the most vital diminsions of its services to rural physicians. Faculty appointments at WVSOM keep rural physicians liked with the college and its educational and clinical environment. Access among the college and rural sites is now progressing with telecommunication linkages. It is expected that rural continuing medical education programs will also be delivered by that medium.

The *Southeastern College of Osteopathic Medicine* (North Miami Beach, Florida), since its founding in 1979, has had rural health training as one of its three major objectives. Beyond the required 18-hour didactic course in rural health, each student is required to serve at least a one month clinical rotation in a rural area. However, almost half of all students elect or are assigned three months of rural medicine to fulfill their ambulatory care requirement. Thus, approximately 200 student months each year are spent in underserved rural areas or facilities. Most rotations are done in Community Health Centers throughout Florida, including such high impact areas as Clewiston, Indiantown, and Belle Glade, which has the highest per capita AIDS population in the U.S. The attending physicians, many of whom are National Health Service Corps physicians, supervise student training in rural medicine.

The success of this rural program led to the Federal funding of SECOM's Everglades Area Health Education Center (AHEC). This activity earned such a good reputation in a very short time that administrators of a Federally-funded health center in central Florida created the impetus for a second AHEC, nearly doubling the service area of the original AHEC. SECOM conducts clinical training in these underserved areas to allow students to experience the challenges of underserved practice, and to treat multilingual, multiethnic, and indigent populations, which they may not have otherwise experienced. In addition, these medical and other health professions students may see parts of Florida to which they may seriously consider returning to practice.

A summer survey program conducted by students has grown into a Statewide project that has identified healthcare needs in rural communities in Florida. The Practice Opportunities Program (POP) began as a project of the (AHEC) program. Three enthusiastic first year medical students embarked on a pilot program as graduate assistants in the summer of 1986. Their task was to develop and field test a community survey to be used by SECOM students and residents for assessing various small communities as possible practice sites upon graduation. Over the next two years, a total of 18 students used their summer vacations to conduct these surveys in over 100 identified small towns. The Directory of Florida Rural Practice Sites for Health Professionals (March 1989) is the culmination of many hours of hard work by the SECOM students and AHEC staff. Their wish is to provide rural communities with an opportunity to be recognized by current and future health professionals who might want to practice in a small town. SECOM believes that even a small percentage doing so would eliminate underservice in many key rural areas of Florida.

In 1980, the **Texas College of Osteopathic Medicine** (Fort Worth) became the first medical school in the nation to commit itself to a curriculum built around the promotion of health. Their approach changed the emphasis in education from "defensive" treatment of disease to "offensive" promotion of health. While recognizing the responsibility to train students to attack existing disease in the traditional manner, the college, with its continued and complete emphasis in the wholistic, comprehensive care philosophy of osteopathic medicine, concentrates equally on training future physicians to promote health and wellness among their patients. The school searches for students whose personal philosophies are compatible with these goals. This commitment is incorporated in the school's core clinical clerkship in ambulatory care and its training at its two rural clinics in Justin and Godley, Texas. These initiatives are designed to address the broad and diverse unmet rural health care needs within Texas and adjoining States. Within this curriculum is a substantial geriatric component, which is crucial to TCOM training mission, due to the large percentage of elderly in rural Texas. The clinics offer students clinical experiences in small communities, the opportunity to assess the health needs of rural Texas and to participate in community projects, and the exposure to potential practice opportunities in medically underserved rural areas after completion of postdoctoral training. TCOM is exploring the possibility of establishing an Area Health Education Center to complement its rural health care delivery and training activities.

The **Chicago College of Osteopathic Medicine** operates a "down-State" rural preceptorship program through its Department of Family Medicine. Approximately 33 seniors currently participate in a one month rotation with a physician preceptor. The school expects to expand the program to 40 students this Fall. Each student is assigned to a rural osteopathic physician with hospital privileges, and practices in emergency medicine, obstetrics/gynecology, general practice, sports medicine, nursing home/geriatric care, and/or prison care. The emphasis is on community medicine. The students attest that the comprehensive, "hands-on," continuity care experience builds their self-confidence in clinical competence. In addition, the student preceptors report exceedingly warm receptions from the rural communities. The experience has dispelled the myth and negative image of rural practice in that the students see it leading to comprehensive clinical responsibilities in well-equipped, well-staffed, and computer-linked practices, accessible to networks of available D.O. and M.D. specialists. All previous participants have credited this program with giving them a previously unseen, but thoroughly positive and more expansive, view of rural medicine as a viable career option. The College has now expanded training opportunities for family medicine residents to allow them to elect up to six months in rural medicine in the last year of family practice residency training.

The **Ohio University College of Osteopathic Medicine** (Athens) was established in 1975 by the State legislature specifically to train general practitioners for medically underserved areas of Ohio. Although only 10 percent of the State's physicians were D.O.s in 1975 when the school was authorized, they handled 25 percent of the primary patient load. As expected, the presence of the school in the State has increased those percentages significantly.

During the third year, students spend eight weeks with general/family practitioners, many in rural areas. In the final 17 months of medical school, which is their "fourth year," students are required to schedule twelve weeks of general/family practice and sixteen weeks of electives with approved preceptors, again, many having practices in rural settings. The 93 graduates in 1988 scheduled 136 clerkships in rural areas, 55% of which were in general/family practice, and 22% in primary care and geriatrics. In addition, the Colleges's AHEC program provides training for OU/COM students throughout the rural communities of Appalachia Ohio. The Consortium of Health Education in Appalachia Ohio (CHEAO) is an integral part of the College of Osteopathic Medicine, which provides continuing medical education programs to health professionals (E.g., physicians, dentists, nurses, and pharmacists) throughout the 18 rural counties of Southeast Ohio.

The **College of Osteopathic Medicine of Oklahoma State University** (Tulsa) was founded in 1972 with the principal public purpose of providing primary care physicians to small towns and rural areas of Oklahoma that are deficient in physician manpower. This goal has been accomplished by means of didactic curriculum, college-affiliated outpatient clinics, a broad Federally-supported Area Health Education Center (AHEC), hospitals, and other health-related clinics. Of paramount importance is that the medical school encourages students to seek admission who want to become general practitioners. Since 1984, through the Oklahoma AHEC (OkAHEC) programs, the entire State's rural health needs are being addressed through organized participation of the entire range of health professions, such as osteopathic medicine, optometry, and nutrition, in such areas as diabetes, heart disease, cholesterol, teen pregnancy, mental health, and organ and tissue transplants. The program has helped COM/OSU establish sites at rural hospitals to promote clinical education and student internships in rural Oklahoma. Currently, support exists for one or two senior osteopathic medical students per month in seven sites in eastern Oklahoma. Coverage of western Oklahoma is anticipated in the next phase. Since the establishment of the two eastern Oklahoma centers in 1985, more than 200 programs have been conducted at remote or rural sites, providing continuing medical education, consumer education, and minority health career recruitment to more than 12,000 health professionals, students, and consumers. The vast majority of the small, rural isolated counties in Oklahoma have become practice locations of osteopathic physicians.

The **Philadelphia College of Osteopathic Medicine** operates rural outpatient health care centers which furnish medical care to rural communities and provide education in family medicine to students. In 1970, the college expanded its program in rural health care delivery with the opening of its own rural health, outreach, and training center in Laporte, Pennsylvania. Located in Sullivan County, it is the major rural facility within PCOM's Community Health Care Center (HCC) rotations for fourth year PCOM medical students. This is a *mandatory* 12-week community medicine rotation, which also allows for an urban rotation, and is designed to provide comprehensive clinical competence and participation in community-oriented ambulatory medicine. The comprehensiveness and length of these programs are designed to establish a sense of patient continuity, thereby enhancing health promotion and disease prevention. In addition, PCOM has affiliated HCC rotations in both urban and rural settings, including a group practice rural model, a rural ambulatory facility, and a primary care HCC rotation alternative. This last option is designed to increase the scope of primary care experience by affording the opportunity for those students who desire to obtain training and experience in a non-traditional, alternative setting, which can include the Indian Health Service, or another rural underserved area with critical medical need. PCOM is seeking to establish, as part of HCC rotations, three or four NHSC/IHS sites with three members each. A preceptorship program also is available in the third year to provide extensive exposure to comprehensive rural health care practice.

PCOM is attempting to expand its rural health care programs, but could be faced with net losses, despite the interest with students and severe unmet need of underserved rural populations. Limited Federal and State facility and practitioner reimbursements have been identified as major obstacles, as well as major problems in the numbers of Federally-funded NHSC physicians who could assist in meeting even basic staffing needs, including assurance of 24-hour coverage, and reduction of staff burnout.

PCOM is pursuing relationships with small rural central Pennsylvania colleges through which students would enter PCOM through advanced placement. Working through alumni and community leaders, PCOM would establish rural clinics to provide clinical training to medical students from these rural areas. The networks established with these colleges, clinics, and hospitals would be expected to enhance access to care and serve as a continuing recruitment and retention mechanism.

The **College of Osteopathic Medicine of the Pacific** (Pomona, California) was established in 1977 expressly to prepare general practitioners to provide comprehensive family health care, and to ensure the growth of family medicine in the West, particularly to those areas in where there is an inadequate supply of primary care physicians. Within the osteopathic construct at COMP, students receive clinical training experiences that take advantage of rural, primary care preceptors who can transfer knowledge and clinical skills relevant to the cultural and socio-economic milieu of the Western States to students. In addition, service to rural areas is enhanced with the availability of smaller hospitals and programs which demonstrate successful approaches to establishing outreach clinics in rural settings. Further, COMP's ambulatory clinical training programs expose students to rural sites that, along with practice management courses, provide the student and physician with the ability to take advantage of the ways and means to develop cost-effective primary care delivery systems that can later be incorporated into practice.

The **University of New England College of Osteopathic Medicine** (Biddeford, Maine) is the only college of osteopathic medicine in New England and the only medical school in Maine. Two primary goals are the education and placement of primary care physicians who will practice medicine in the underserved rural and urban areas of New England and the provision of training at lower cost than alternative models. Both the didactic curriculum and clinical training programs emphasize the knowledge and skills basic to osteopathic general practice. The College's Area Health Education Center (AHEC) grant allows significant multidisciplinary training and service delivery in the New England region.

Recognizing that Iowa is almost totally a rural State, the **University of Osteopathic Medicine and Health Sciences College of Osteopathic Medicine and Surgery** (Des Moines, Iowa) requires a six-month rotation in ambulatory care in hospitals, affiliated clinics, and a network of affiliated preceptor private physicians throughout the State. These rotations also incorporate rural multidisciplinary training exposure with the school's pediatric and physicians' assistant programs. About twenty percent of each graduating class establish practices in Iowa, with about 70% of that number remaining in rural Iowa. The school attributes this success to the ambulatory rotation, and is pleased with the results, even though the school is considered a national school. Many other graduates are believed to retain this rural interest in their practice decisions in other States.

The school's major rural clinics program that once provided access to services to underserved populations, as well as training for students through three clinics, has seen one clinic close, due to limited reimbursement in rural areas and lack of staff. The school believes that partial NHSC physician staffing might have improved the prospects for its continuance. The school will be applying for an Area Health Education Center (AHEC) grant that will seek funding for initiatives that will emphasize the use of rural facilities in training. In a so-called "self-directed learning program," students would be detached from the main campus, receiving two-thirds regular classroom instruction complemented by telecommunications hookup, coupled with one-third preceptor training in the rural areas.

The **Michigan State University College of Osteopathic Medicine** (East Lansing) maintains an emphasis in rural medicine through its preceptorship program. Through this initiative, medical students spend one afternoon a week in the office of a practicing physician, who often is in rural health care practice. Because of the primary care nature of the osteopathic medical training model, significant numbers of graduates are exposed to the comprehensive care concepts of osteopathic medicine that prepare them for practices in rural and underserved areas. MSU/COM participates in the AHEC of the allopathic medical school program at MSU, and is considering establishing its own AHEC, building upon successes of previous MSU programs for the rural areas of the Upper Peninsula (UP) of Michigan and other underserved areas of the State.

The **University of Health Sciences—College of Osteopathic Medicine** (Kansas City, Missouri) has, for twenty years, required all students to take rotations at rural health training sites all over the country, with emphasis in the States of Missouri and Kansas. Students serve with preceptor physicians in their offices, clinics, and rural hospitals. Because of these close learning experiences, many students return to these underserved rural areas to practice as primary care physicians. All such graduates know they can and do depend on their alma matter for continued postdoctoral consultations with their former professors at the University. Also, they return for continuing medical education programs and conferences, as periodically arranged.

The primary objective of UHS-COM is to teach and train well-qualified students in general practice to become competent family physicians. UHS-COM succeeds in doing so through its admissions criteria, the requirements of its curriculum design, and well-defined faculty responsibilities, all of which emphasize preparation of students for general practice during their four years of academic and clinical experience before graduation. On average, over 60 percent of UHS-COM graduates enter family practice medicine, and a large percentage of those practice in rural settings and medically underserved areas, particularly in Missouri, Kansas, Tennessee, and

Mississippi. In addition, UHS-COM is now considering, establishing an AHEC to further encourage rural community practice opportunities for students and physicians.

Of particular need at UHS-COM is the development of faculty in the departments of family medicine and geriatrics and Ph.D.s to conduct research. Also key would be training materials and textbooks for preceptors and telecommunications linkages between rural sites and the University campus. The University's 50-bed geriatric medical pavilion has a waiting list, and the need for appropriately trained clinicians would assist in enlarging its capacity and patient access to care. Of crucial concern to further enhancing the school's remote site clinical training capacity would be the use of additional NHSC physicians as preceptors in remote site practices and facilities. The University's graduates have demonstrated their commitment to meeting the needs of previously underserved communities. For example, graduates identified the need for physicians in Phillips County, including Phillipsburg, Kansas, where there were no D.O.s or M.D.s. Now there are 4 D.O.s and 2 M.D.s to meet the needs of the rural population. The same commitment and creativity led to the establishment of an osteopathic medical practice in Larened, Kansas.

RECOMMENDATIONS: CURRENT AND FUTURE NEEDS

There will continue to be a significant shortage of physicians in rural America, unless concerted and major initiatives are pursued immediately, including major replacement funding to attract and retain physicians for Community Health Centers, Migrant Health Centers, and rural hospitals and clinics. In addition, innovative training and services delivery support in remote sites will be crucial. Key to the solution of recruitment and retention of physicians in rural areas is the financial attractiveness of practicing medicine in such areas. Financial deterrents to establishing practices in underserved areas, such as low reimbursements, need to be removed.

National Health Service Corps Loan Repayment and Scholarship Programs: Although historically, the NHSC has made inroads into the problem of shortage of primary care physicians in rural and underserved areas, the lack of a continued supply of NHSC scholarship recipients exiting the pipeline will create further havoc in the staffing of community and migrant health centers and rural clinics and hospitals. Adequate replacement support of physicians is essential. There will be a reduction of 700-900 physicians this year due to the ending of obligated physicians coming out of the NHSC scholarship program. In addition, 3,578 are needed to remove the top two of four Priority Group primary care HMSA designations set by HHS. The FY 1989 funding for the NHSC loan repayment program was $8 million including the State component. This program is now administratively "up and running."

Interim final regulations for the NHSC loan repayment program published in the April 2 *Federal Register* contain a few features that may further handicap the nascent program to the point of precipating its failure. One is the fact that the interim final regulations precipitously cut the income tax supplement to 20% from 28%, which had been in force since May 1988. The lower level is to be applied even to those who have agreed to a match and others already are serving. In addition, maximum loan repayment for two year contracts with physicians are restricted to two-thirds of the maximum $20,000 per year, a policy we believe to be contrary to the law. For three and four years contracts, the maximum remains at $20,000 per year. Physicians presenting debt above $26,666 and below $60,000 are being disadvantaged. In addition, although not statutorily permitted HHS has Stated that pre-medical debt is not a qualified educational debt, although baccalaureate and masters degree nursing debts (i.e., totalling six years) are deemed eligible. These policies are counterproductive and contrary to law.

> *Recommendation 1:* At least $15 million for all health professions, with no less than $10 million for physicians, is required for the *NHSC Loan Repayment Program* in FY 1990. Even at this level, only about 140 physicians per year can be supported, far short of the replacement requirements of 700-900 that have lost prior recipients of the NHSC scholarship program, and not to mention the 3,578 primary care physicians needed to remove the primary care physician HMSA designations set by HHS for the top two of four HMSA designation priority groups. To replace the 700 physicians would require at least $75 million per year. However, to reach even a modicum of physician replacement and clinical care, at least $30 million would have to be funded each year over the next five years. The Administration's budget recommendation that this program be turned totally over to the States is premature, since no individuals to date have been placed. Recent testimony indicates that some States are not using the cur-

rent money to recruit physicians into the most difficult to fill underserved areas.

Serious thought should be given to funding new *NHSC Scholarships* at a level of at least $10 million in FY 1990 for physicians. This mechanism can provide needed assistance to committed future physicians and offer a needed planning device for HRSA.

The provision in the law that permits the Secretary to undertake payment of expected tax liability for such loan repayments should be used to the maximum extent to enhance lagging recruitment, and to counter competition from less needy sites that can pay more to attract physicians and nurses/PAs. Two year contracts and contracts over four years should be encouraged at levels comparable to three and four year contracts.

National Health Service Corps Loan Repayment Program Assignment and Selection Criteria: Certain high priority areas and facilities that "have not gone through all the hoops" at HRSA for cost-effectiveness and economic viability have been denied assignment of NHSC physicians and other health professionals. Part of the problem the small, rural, isolated communities face is lack of physician time and administrative know-how to write grant regarding economic or patient requirements that are contained in current HRSA criteria. These communities' need for 24-hour staffing override other considerations. Physician-to-population ratios are not always indicative of the need for physicians or other health practitioners. Medical students and physicians trained in underserved settings are more likely to return to and remain after any services obligation ends.

In addition, medical school remote site training and clinical preceptor staffing needs are paramount to an effective rural (and urban) underserved clinical skills transference experience. Yet the economic nonviability of sites and persistent low reimbursement rates disadvantage medical (D.O. and M.D.) schools from establishing and maintaining such facilities and programs.

Recommendation 2: Medical (D.O. and M.D.) and other health professions schools' underserved area clinical training programs and facilities should explicitly be included among the priority NHSC assignment criteria. Assignment of physicians to health professions schools' remote site training centers and clinics that can be used in the didactic and clinical training of medical and other health professionals should be a priority.

Recommendation 3: Priority for NHSC loan repayment selection should be given to health professionals who are receiving or have received clinical training in rural or other underserved areas or sites and to those who have come from rural areas and desire to practice in these areas.

Recommendation 4: Demographic indicators of need currently used by the NHSC such as the economic accessibility of health care services as measured by poverty levels, the percentage of service areas population without health insurance, and the health status of the population as measured by the rates of infant mortality, low birth weight, teen pregnancy, and geographic barriers are legitimate factors to be considered in NHSC physician assignment decisions in some rural areas. However, the elderly population percentage, endemic rural status, and/or unemployment may also be as important or even more definitive of the need. These additional factors should be explicitly identified as assignment criteria with equivalent or greater priority.

Recommendation 5: It is our understanding that the NHSC currently assigns physicians to Community Health Centers (CHCs) and Migrant Health Centers (MHCs) that are HRSA grantees, and not to other CHCs, MHCs, and rural hospitals. The current NHSC statute does not restrict assignment to present HRSA grantees. The overriding criteria is need. Therefore, current HHS assignment policies should be reviewed.

Recommendation 6: Continuity and Longitudinal Care Requirement: Attention should also be given to reviewing the current HHS requirements that grantees receiving funding under various PHS grants ensure that their trainees to return to the main teaching site from the rural area at more frequent intervals than may be necessary. This disruption to the services delivery needs of the rural area is a big negative factor at some rural sites because of continuous staffing needs.

The Indian Health Service Loan Repayment Program: This program was funded at $2 million in both FY 1988 and FY 1989. This level of funding has been inadequate in meeting the clinical staffing needs of rural IHS sites. Approximately 55 physicians and 40 nurses were supported in FY 1988. However, the annual attrition rate for physicians is about 200-250, and this may be quickened with the loss of prior NHSC scholarship recipient physicians. Significant staffing needs also exist for other health professionals and allied health professionals.

Recommendation 7: Funding of at least $6 million for the Indian Health Loan Repayment Program is necessary for FY 1990. The IHS program should be amended to permit the same tax liability supplement accorded NHSC loan repayment program participants.

Recommendation 8: Indian Health and Native Hawaiian Scholarship Programs: The Indian health scholarship program, and its extern and preparatory scholarship programs, as well as the Native Hawaiian program demand full funding in FY 1990 if rural health needs of these population groups are ever going to be met.

HHS National Advisory Council on Rural Health: The House of Representatives' Rural Health Care Coalition and the Senate Rural Health Caucus were moving forces in the Administration's creation of this council. Osteopathic medical education has played an historic and consistently strong role in educating and placing physicians in rural America, especially in small rural, isolated towns and counties that have otherwise not benefitted from Federal programs designed to address rural needs. Yet during the initial appointment process, **no representative of osteopathic medical education was named.** The Federal advisory committee process would benefit from the formal contribution of such a representative. One such representative is included on the Congressional Office of Technology Assessment panel on rural health.

Recommendation 9: The HHS National Advisory Council on Rural Health should be created by statute, and representatives of osteopathic and allopathic medical education should be mandated as continuing statutory members.

Graduate Medical Education Changes Relative to Reimbursement, Rural Areas, Ambulatory Care and Primary Care: The level and mechanism of reimbursement of graduate medical education costs can have a dramatic effect on the development of programs that can correct imbalances in geographic and specialty distribution of physicians. The HHS Council on Graduate Medical Education (COGME) recognized the particular difficulty experienced by rural and urban underserved areas in attracting adequate numbers of primary care physicians to geographic areas of need.

In addition, the Physician Payment Review Commission (PhysPRC) reached similar conclusions. We agree with Dr. Philip R. Lee, Chairman of PhysPRC, who said, "Increasingly, training for primary care physicians must shift from the hospital inpatient setting to the ambulatory care setting. However, because of the costs entailed, training in ambulatory care settings can take place only if the costs can be adequately covered—as the costs of inpatient training are covered—through third party payments."

Continuing studies of various groups, particularly the PhysPRC and COGME, have demonstrated the inequity of payments for primary care physicians relative to other physicians, as well as the inappropriate current reimbursement differentials between rural and urban physicians. We applaud these reviews and believe changes will inure to the benefit of our medical schools' training programs, especially the **creation and maintenance of satellite rural health clinics** (for physician staffing, service delivery, and training of students) and the patients our graduates will treat. Set forth below, as Recommendations 8, 9, and 10, are summaries of the 1988 COGME recommendations relevant to rural health, ambulatory care, and primary care training, which AACOM endorses:

Recommendation 10: The highest priority should be placed on reimbursement of residency training stipends and fringe benefits costs, training in primary care specialties which are in short supply, **training in preventive medicine and geriatrics, support of quality GME programs in underserved communities,** and support for the training of minorities. If reductions are made in the reimbursements for the direct costs of GME, these areas should be sheltered from the impact. [Variation of COGME Recommendation 16]

Recommendation 11: To facilitate the expansion of ambulatory/outpatient GME, and to encourage innovative program development and growth, such as in rural and other underserved areas, **all approved GME programs, including those based in ambulatory/outpatient settings, should be eligible for Medicare GME reimbursement.** A methodology for reimbursement of direct and indirect costs for ambulatory training should be developed. [Variation of COGME Recommendation 18]

Recommendation 12: Medicare and private organizations should carry out **demonstrations of alternative methods of payment for GME in ambulatory**

and other nontraditional settings, such as remote site medical (D.O. and M.D.) school training programs and clinics. It may be necessary to consider differential payment incentives to encourage and facilitate medical education in ambulatory and long-term care sites. [Variation of COGME Recommendation 19]

The Area Health Education Centers (AHEC) program has been a model program over the last 16 years in providing decentralized training and health services delivery in rural and other underserved areas. Seven of our schools currently receive Federal and/or State support, with three or more hopeful this year. However, as was recognized during the renewal of this authority last year, the need far exceeds the erosion of funding this program experienced over the last few years. The authorization level for FY 1990 is $20 million. A new, AHEC-like program, designed for both Mexican border and other urban and rural areas (including frontier areas) that can demonstrate serious unmet health care needs, including health promotion and disease prevention, is authorized at $8 million for FY 1990.

> **Recommendation 13:** Both the traditional **AHEC** and AHEC-like "border" programs ["Health and Education Centers"] should be funded at their full authorized levels of $20 million and $8 million, respectively. These levels are necessary to allow appropriate program expansion in areas of previously identified need and to attack more forcefully indigenous health care needs.

The Interdisciplinary Rural Health Care Training Program [PHS Act, Section 799A] also was created last fall, and is designed to support interdisciplinary training projects that would use new and innovative methods to train interdisciplinary teams of health care practitioners. Such support would enhance the provision of health care services in rural areas, increase access to cost-effective, comprehensive care, permit an increase in the amount of relevant research in rural health care, and increase the potential for recruitment and retention by assisting in making rural health care a more attractive career choice. Our schools could develop interdisciplinary training and service delivery programs in communities that do not have the current economic bases to support such practices. The "hands on" exposure of health professions students to these areas and this type of practice has been shown by our schools and in studies to result in significant numbers of these individuals remaining in locations in which they were born, grew up, and/or trained after completion of training.

> **Recommendation 14:** The new **interdisciplinary rural health care training** program should be funded at the full authorization level of $5 million in order to provide prompt attention to indigenous unment health care needs and to take advantage of current interdisciplinary educational initiatives and research and the multidisciplinary health care needs of rural America.

Federal Geriatric Training Program: [PHS Act, Section 789(b)]: Current law requires that each osteopathic medical training program that seeks to train physicians who plan to teach geriatric medicine must provide for a staffing relationship with dentists who have experience or training in geriatric dentistry. This otherwise model Federal program could prove to be crucial to our rural-oriented schools in meeting the geriatric training (and service) needs of osteopathic physicians and their patients. However, the requirement that each program include a geriatric dental teaching component effectively has eliminated some otherwise high quality osteopathic rural geriatric programs from competing, due to their present geographic and structural limitations.

> **Recommendation 15:** The current geriatric dental faculty teaching requirement should not apply to initial osteopathic applications and awards, but that once awarded, an institution should be required to make a good faith effort to incorporate a dental component within the curriculum. In this way, the current rural and/or geriatric faculty training needs of osteopathic programs would not be compromised.
>
> **Recommendation 16:** Both the **geriatric faculty development programs [Section 789(b)] and the geriatric education centers program [Section 789(a)],** funded by the Public Health Service, should be funded at their full FY 1990 levels, due to the significant positive impact they can continue to have in rural areas.

Other Primary Care Training Authorities: All current primary care training programs in Title VII of the Public Health Service Act provide basic programmatic structure and funding for health professions schools and have significant influences on the needs of rural America. It is primary care practitioners who develop the skills to go into rural underserved areas and establish practices where physicians are most needed to deliver comprehensive primary care medicine. Due to present inequitable reimbursement policies, many programs are not capable of being self-sufficient.

> **Recommendation 17:** There must be continued support and development of residency training capacity of **family physicians** [Section 786], **general internists and general pediatricians** [Section 784], and **preventive medicine** physicians [788(c)]. In addition to residency training grants, the Public Health Service Act authorizes the support of **Departments of Family Medicine** [Section 780], and physician assistant programs [Section 783], all of which have significant rural health components. These should be funded at their fullest levels.

The Exceptional Financial Need Scholarship Program for Disadvantaged Students [Section 758], the Health Career Opportunity Program (HCOP) [Section 787], and the new Recruitment and Retention Program for Disadvantaged Students [Section 787A] can play an important role in attracting qualified disadvantaged students to colleges of osteopathic medicine who can be expected to translate their comprehensive, primary care knowledge into practice in rural and other underserved areas.

> **Recommendation 18:** The EFN and HCOP programs and the new recruitment and retention program for disadvantaged students should be funded at their fullest authorized levels.

Federally-funded Locum Tenens Program: One of the most difficult problems in recruiting and retaining physicians to practice in rural, isolated communities is the fear and reality of the 24-hour on-call nature of service, "burnout," sickness (with no one to fill in), the need and desire to attend continuing medical education meetings, vacations, and teaching opportunities. Knowing that their practices would be covered in such circumstances would make locating in rural communities more attractive to new physicians who are choosing a practice site.

> **Recommendation 19:** A Federally funded **locum tenens** program should be created within existing HHS authority, if possible, or otherwise developed as a new statutory program. This would allow medical (D.O. and M.D.) schools or other entities to receive funds or contract with physicians to provide a specific number of days of practice coverage for physicians in medically underserved areas.

Veterans Administration Contracts for Rural Area Health Care: Many veterans forego needed medical care rather than drive 90 to 200 miles for such services. This situation is inconsistent with this country's Stated desire to increase and maintain access to health care services for its citizens. It also should be remembered that twice as many rural residents are elderly than in the U.S. as a whole. Many of this nation's veterans are elderly.

> **Recommendation 20:** There should be developed a mechanism whereby the **Veterans Administration would contract with hospitals and clinics in rural areas** so that veterans can receive care in their own communities, ensuring appropriate and needed health care access.

Restoration of the Full Tax Deduction of Student Loan Interest and Tax Credits: This restoration could be a major factor in attracting otherwise committed and compassionate primary care physicians to rural and other underserved areas. Current legislation before the Congress, such as H.R. 747 and S. 656 would restore the full tax deductibility of student loan interest for all loans. Other legislation, recently introduced, would permit this deduction only for service in health manpower shortage areas or medically underserved populations. Although the needs for underserved areas are great, the current tax code maintains an inequity for student loans in general, by allowing home equity loans and first and second home mortgages to fully qualify for full interest tax deduction and not student loan interest (after 1990, the last year of phase-out). It is our belief that such a universal correction will inure to the benefit of rural areas by making them more financially attractive. The cost is expected to be $50 million for all student loans in FY 1990, and $100 million in 1991. No estimate is available just for medical loans. Tax credits for service in HMSAs can also be successful in meeting the needs of underserved areas.

> **Recommendation 21:** H.R. 747 and S. 656 should be enacted to restore full deductibility of student loan interest for all student loans. Other mechanisms, such as tax credits for service in underserved areas, also should be supported as complementary approaches to meeting needs of rural and other underserved areas.

Additional information can be obtained from AACOM, through the following individuals: Sherry R. Arnstein, AACOM Executive Director, (301) 468-0990; Roger C. Courtney, Esq., AACOM Director of Government Relations, (202) 467-4131; R.B. Fenninger, AACOM Government Relations Consultant, (202) 371-8090.

STATEMENT OF THE COUNCIL FOR SMALL AND RURAL HOSPITALS OF THE SOUTH CAROLINA HOSPITAL ASSOCIATION

Mr. Chairman, I am Lawrence H. Chewning, Administrator of Wallace Thompson Hospital in Union, South Carolina, and Chairman of the Council for Small and Rural Hospitals of the South Carolina Hospital Association. On behalf of the Council and its 39 members, I appreciate the opportunity to comment on the plight of small and rural hospitals in South Carolina.

SIZE AND DISTRIBUTION

In South Carolina, thirty-nine hospitals or 56% of all community hospitals are rural (by Federal definition). Twenty-three of these facilities are small (less than 100 licensed beds) and rural. Rural South Carolinians depend on these facilities not only for health care, but also for the economic development of their community. The rural hospital is often the largest or second- largest employer in the community, and its survival is necessary for attracting physicians, as well as other business and industry to the community.

While most of the rural hospitals in South Carolina have less than 100 licensed beds, there are seventeen rural facilities with more than 100 licensed beds, two of which are rural referral centers with a licensed capacity of 397 and 286 beds.

FACILITIES, SERVICES AND UTILIZATION

In 1987, South Carolina rural hospitals admitted 119,195 patients and provided 957,563 inpatient days of care, representing over a third of total inpatient days Statewide. Despite their size and isolated locations, in this same year South Carolina's rural community hospitals managed to keep 63.3% of their beds occupied, compared to the national average of 55.3% during the same time period.

Most rural hospitals have reduced their staffs in order to maintain efficient operations and increase productivity. While South Carolina rural community hospitals have a slightly higher average number of full-time equivalent employees (2.5) than the national average for rural hospitals (2.3), they have kept expenses down to $2,447 per admission, compared to the national average of $2,532 per admission.

Rural communities in South Carolina depend on revenues generated by outpatient services to support their overall operations, as do urban facilities. In 1987, almost 21% of the total gross patient revenue of the State's rural community hospitals came from outpatient services. Also, these rural community hospitals are shifting to outpatient services at a faster rate than their urban counterparts, experiencing a 9% growth rate from 1980 to 1987 compared to a 5% growth rate for urban hospitals.

Compared to urban hospitals in South Carolina, rural hospitals tend to have a greater share of Medicare and Medicaid patients. In 1987, 49.94% of discharges in rural hospitals were Medicare and/or Medicaid patients, compared to 39.49% in urban hospitals.

Of greater concern is the divergence between the two groups in percentage of patient days. In rural hospitals, only 37.9% of patient days were from nongovernmental sources. This compares to 50.5% for urban hospitals.

With low occupancy rates and a disproportionate percentage of government-sponsored patients, South Carolina rural hospitals have seen profit margins deteriorate. These trends threaten the economic survival of rural hospitals.

FINANCES: SOUTH CAROLINA RURAL HOSPITALS UNDER PROSPECTIVE PRICING

Since 1980, South Carolina's hospitals, both urban and rural, have continued to face increasing deductions from gross patient revenue. The average hospital in 1987 failed to collect 25.1% of billed charges because of government underpayments, indigent care, and bad debt. That means the privately insured patient had to pay 25.1% more, on average, to support government- sponsored patients, as well as those underinsured patients who could not or would not pay their own bills. Prior to the introduction of the Medicare Prospective Pricing System (PPS) in 1983, urban hospitals' deductions as a percent of gross patient revenue exceeded that of the rural hospitals. Since its inception, PPS has resulted in a widening gap between the urban and rural hospitals' deductions as a percent of gross patient revenue.

In total dollars, the largest deductions from gross patient revenues are Medicare and Medicaid contractual allowances—the difference between billed charges and government payments. As a percentage of gross patient revenues, these deductions have increased for both rural and urban hospitals. Shortfalls in these programs have increasingly impacted rural hospitals due to their patient mix.

A look at operating margins bears this out, as rural hospitals in South Carolina have seen their average operating margin deteriorate from 3.5% in 1984 to -8.0% in 1987. This is compared to an average margin of 3.7% in 1987 for urban hospitals, down from 5.1% in 1984. With a much smaller base of paying patients to shift unreimbursed costs to, many small rural hospitals are approaching the financial breaking point.

South Carolina rural hospitals have been severely impacted by the PPS pricing which pays urban hospitals more than rural hospitals for the same treatments provided on a per case basis. Nationally, the average payment per case for a rural hospital is only 57% of the average payment per case for an urban hospital.

In 1988, South Carolina rural hospitals lost approximately $19 million dollars (see attached Chart No. 1) in Medicare revenues due to the urban/rural differential. This kind of payment disparity under Medicare, coupled with growing numbers of uninsured and underinsured patients, seriously undermines the ability of rural hospitals to survive.

RECOMMENDATIONS

The Council applauds the "Elect to Protect" and "Resolve to Protect" advocacy campaign spearheaded by the AHA this past year and has actively participated in all of its phases. We also conceptually support the AHA PPS Reform Initiative and accept its use in developing positions on various Medicare legislation introduced in Congress. However, there are a number of key points that we believe need to be addressed both with the AHA reform package and legislation currently being considered in Congress.

The AHA has based its position on PPS reform on the premise that prices set must be both adequate and equitable. AHA recommends movement to a single base rate, adjusted for differences in the kinds of patients admitted to hospitals and for differences in the prices hospitals must pay for resources. A number of bills introduced during the 101st Congress to deal with PPS-related problems faced by rural hospitals embrace many of the principles contained in the AHA reform package. A major focus of all of these bills would be elimination of the urban/rural differential over varying lengths of time.

RECOMMENDATION No. 1: The current payment differential should be phased out no later than October 1, 1990, with a single base rate established no later than October 1, 1993.

AHA data shows that under current law nearly two-thirds of all hospitals will lose money caring for Medicare patients in FY 90, with payments by Medicare to the average hospital falling short of costs by almost 9%. It appears that movement to a single national rate in a budget neutral manner could well create as many problems as it eliminates. AHA, therefore, insists that movement to a single rate must be accompanied by a "hold-harmless" provision, which protects hospitals from any actual reductions in payment. While SCHA does not support efforts to achieve a base rate simply by cutting urban hospital payments to increase rural hospital payments, it also is aware that deteriorating margins place our small rural hospitals at greater risk during this transition period.

RECOMMENDATION No. 2: While the urban/rural differential is phased out, rural hospitals should receive percentage increases in PPS rates in excess of the hospital market basket.

The AHA PPS Reform Initiative calls for continued use of metropolitan statistical areas (MSAs) in calculating area wage indices until an overall resource price adjustment is developed. Not only are the data used to calculate this index flawed and out-of-date, but the current methodology does not reflect prices paid by hospitals in local markets. By calculating a Statewide rural average wage index, hospitals at opposite ends of a State are grouped together, rather than compared to hospitals within and around the nearest MSA, where competition for nurses and other trained personnel exists.

RECOMMENDATION No. 3: HCFA should employ an alternate methodology for grouping hospitals that reflects the "real" world in terms of institutions recruiting skilled health professionals from the same labor pool. Until an overall resource price adjustment is developed, HCFA should calculate an adjustment for hospital salaries on a regional basis, rather than by MSA (as proposed by H.R. 2246).

With prices based on average cost-per-discharge, the "law of large numbers" must be present. For a significant number of rural hospitals there is not a sufficient volume of discharges for PPS to work as intended. One compelling factor influencing the low margins being experienced by rural hospitals is the disproportionate impact of even one expensive outlier case on a small facility. AHA is requesting that rural hospitals operating fewer than 50 beds be given the option to receive cost-based payments, while various bills being introduced stipulate hospitals with 100 or fewer licensed beds. The legislation also varies in terms of the criteria that would be established for those hospitals needing additional payment during the transition period.

RECOMMENDATION No. 4: All hospitals operating 100 or fewer beds should either be able to opt out of PPS during the transition period or be eligible for a payment add-on. Any legislation referring to licensed beds ignores the fact that beds in operation are the key in terms of identifying those facilities with an insufficient volume of discharges to make PPS work.

RECOMMENDATION No. 5: Any volume threshold established should include both Medicare and Medicaid discharges. The plight of rural hospitals today results from their payor mix, with fewer paying patients to shift unreimbursed costs to (See attached charts 2A and 2B).

SUMMARY

The deteriorating financial condition of many rural hospitals indicates that changes are needed in the way care is organized, delivered, and financed. The South Carolina Hospital Association is working with State and local government to facilitate this restructuring. With the financial assistance of various foundations, rural hospitals are also exploring possible alliances and affiliations which would be responsive to both changing patterns in the delivery of care and local community needs and capabilities.

In recognition of the enormous pressures facing the health care industry, and understanding that Medicare cannot be expected to solve all rural hospital problems, South Carolina rural hospitals are exploring many other initiatives to strengthen their capabilities. Many are involved in in-depth strategic planning processes to assure their survival so that they can continue to provide quality care to rural South Carolinians. The Federal Government must take steps to ensure that Medicare does not add to the fiscal pressures and that PPS is more reflective of rural economic conditions.

CHART #1

GENERAL & FINANCIAL INFORMATION ABOUT SMALL & RURAL HOSPITALS

RURAL HOSPITALS	Miles to Urban Hosp.	Staffed Beds[1]	Avg. Census[1]	1986 Net Income[2]	1987 Operat. Expenditures[2]	1987 FTE[2]	1987 Salaries[2]	1987 Net Income[2]	1988 Medicare Loss (Chart 2)
Abbeville County Memorial	30	52	20	$237,847	$3,366,300	88	$1,636,114	($187,586)	($264,047)
Allendale County Hospital	52	40	15	$118,921	$2,530,739	47	$838,917	($53,013)	($216,537)
Bailey Memorial Hospital	20	68	25	$316,576	$4,736,684	117	$1,786,142	$213,514	($389,621)
Bamberg County Memorial	47	59	40	($292,132)	$5,694,720	119	$2,165,534	($333,845)	($490,027)
Baptist Med Ctr, Easley	*	109	64	($80,287)	$14,880,083	310	$6,279,604	($341,294)	*
Barnwell County Hospital	35	53	25	($39,194)	$2,810,805	86	$1,057,122	($761,854)	($325,065)
Beaufort County Memorial	38	99	57	$882,682	$11,135,656	286	$5,130,329	$1,594,828	($696,083)
B. J. Workman Memorial	*	43	18	($17,879)	$2,980,044	72	$1,345,612	($152,520)	
Byerly Hospital	10	104	62	$601,697	$9,169,374	231	$3,853,487	$127,355	($454,256)
Cannon Memorial	*	56	27	$206,652	$5,247,690	125^3	$2,097,800	($1,069,758)	*
Chester County Hospital	20	79	49	$727,730	$9,627,348	242	$4,025,142	$227,073	($678,940)
Chesterfield General	39	72	26	($273,675)	$7,569,014	146	$2,481,530	($376,186)	($210,036)
Clarendon Memorial	44	56	35	($169,952)	$4,931,527	140	$2,300,092	$139,577	($290,279)
Colleton Regional	48	145	56	($112,602)	$12,051,854	243	$4,204,383	($539,169)	($891,783)
Conway Hospital	46	142	90	$438,205	$18,575,374	406	$7,362,909	$1,169,673	($750,008)
Divine Savior Hospital	*	51	20	$36,241	$3,853,552	83	$1,226,467	($101,737)	*
Edgefield County Memorial	22	40	17	($153,049)	$2,336,367	69^3	$1,139,548	($311,738)	($208,094)
Elliott White Springs	23	124	96	$386,208	$17,621,450	327	$7,480,378	($981,291)	($1,182,874)
English Park (closed 6/88)	22	50	21	($469,216)	$4,001,825	81	$1,437,235	($610,628)	($115,996)
Fairfield Memorial	28	27	13	($540,495)	$3,761,593	97	$1,747,889	($228,816)	($228,763)
Georgetown Memorial	55	132	102	$1,261,689	$16,965,226	358	$6,782,609	$1,789,518	($1,145,455)
Grand Strand General	58	133	92	$2,536,225	$21,687,002	403	$7,445,244	$3,048,462	($1,306,558)
Hampton General	63	68	19	($31,309)	$2,246,713	78^3	$990,268	$2,410	($278,304)
HCA Aiken Regional	*	190	120	$2,885,323	$23,328,652	452	$8,506,095	$1,732,317	*
Hilton Head Hospital	36	64	35	$1,195,260	$11,137,156	211	$4,131,615	$755,661	($606,565)
Hope Hospital	20	16	6	($22,420)^3	na	10^3	$181,315^3	($121,007)^3	na
Kershaw County Memorial	32	92	62	$919,908	$13,222,048	340	$5,764,107	$425,230	($920,312)
Laurens District	19	47	30	$261,317	$4,228,085	118	$1,833,227	$48,544	($575,292)
Lee County Memorial	34	35	11	$140,826	$2,049,515	59	$959,375	($99,904)	($99,745)
Live Oaks Hospital	30	31	18	$347,268	$2,359,947	57^3	$891,278	($372,943)	($297,228)
Loris Community Hospital	56	105	53	($126,417)	$10,289,889	235	$3,653,302	($36,208)	($570,169)
Lower Florence Hospital	*	48	28	($53,333)	$3,914,449	112	$1,703,595	($138,875)	*
Marion Memorial Hospital	22	63	43	$186,540	$7,708,722	211	$3,221,371	$202,608	($385,584)
Marlboro Park Hospital	38	111	43	$30,089	$8,687,891	174	$3,168,069	$7,024	($410,006)
Mullins Hospital	30	80	52	$1,636,720	$7,508,565	206	$2,817,342	$462,935	($484,647)
Newberry County Memorial	40	102	46	$407,649	$7,177,092	188	$3,173,315	($162,715)	($566,656)

CHART #1 (cont.)

GENERAL & FINANCIAL INFORMATION ABOUT SMALL & RURAL HOSPITALS

RURAL HOSPITALS	Miles to Urban Hosp.	Staffed Beds[1]	Avg. Census[1]	1986 Net Income[2]	1987 Operat. Expenditures[2]	1987 FTE[2]	1987 Salaries[2]	1987 Net Income[2]	1988 Medicare Loss (Chart 2)
Oconee Memorial Hospital	23	111	83	$586,453	$17,148,223	437	$8,358,329	($313,925)	($1,208,193)
Southland Medical	10	52	20	($217,054)	$4,535,476	80	$1,616,964	($419,285)	($156,551)
St. Eugene Community	32	70	58	$808,443	$9,845,185	278	$4,396,837	$74,374	($458,130)
Upstate Carolina	20	143	66	($1,297,450)	$10,729,159	216	$5,004,439	($1,201,749)	($876,719)
Wallace Thomson Hospital	27	92	56	($961,301)	$9,347,563	247	$3,305,005	($2,497,118)	($816,119)
Williamsburg County	27	60	36	($113,687)	$7,351,533	188	$3,045,864	($1,073,039)	($262,554)
Wilson Clinic	10	50	32	$1,046	$5,462,502	136	$2,097,614	($180,363)	($321,693)
TOTALS		3364	1882	$12,186,063	$353,812,592	8107	$142,643,413	($645,463)	($19,138,889)

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[1] Based on 1986 data provided by the Division of Research & Statistical Services

[2] From FY 1986 and 1987 Medicaid cost reports filed with HMSFC (unaudited)

[3] Estimated

* In county designated urban by Medicare

hcp&oc
9/88

CHART # 2A

RURAL COMMUNITY HOSPITALS, SOUTH CAROLINA -- 1987

HOSPITAL	% MEDICARE DISCHARGES	% MEDICARE PATIENT DAYS	% MEDICARE REVENUE
ABBEVILLE COUNTY MEM	38.50%	55.52%	48.10%
ALLENDALE COUNTY HOS	38.31%	49.58%	45.84%
BAILEY MEMORIAL HOSP	33.09%	52.49%	36.03%
BAMBERG COUNTY MEM H	36.90%	51.47%	47.89%
BARNWELL COUNTY HOSP	45.48%	66.74%	72.40%
BEAUFORT MEMORIAL HO	21.97%	36.03%	29.19%
BYERLY HOSPITAL	31.45%	44.44%	39.63%
CHEROKEE MEMORIAL HO	35.72%	51.19%	44.93%
CHESTER COUNTY HOSPI	34.58%	50.62%	41.09%
CHESTERFIELD GEN HOS	24.87%	38.31%	30.85%
CLARENDON MEMORIAL H	35.94%	49.52%	40.03%
COLLETON REGIONAL HO	42.14%	54.97%	45.89%
CONWAY HOSPITAL	31.30%	41.70%	34.66%
EDGEFIELD COUNTY HOS	36.25%	22.00%	41.99%
ELLIOTT WHITE SPRING	33.19%	30.53%	34.84%
FAIRFIELD MEMORIAL H	45.78%	38.18%	49.24%
GEORGETOWN MEMORIAL	30.43%	45.22%	42.63%
HAMPTON GENERAL HOSP	34.73%	49.67%	41.23%
HCA GRAND STRAND GEN	43.08%	58.57%	44.42%
HILTON HEAD HOSPITAL	31.28%	39.48%	37.10%
HOPE HOSPITAL	0%	0%	0%
KERSHAW COUNTY MEM H	31.55%	48.17%	39.92%
LAURENS DISTRICT HOS	42.84%	62.59%	51.39%
LEE COUNTY MEMORIAL	30.43%	24.27%	46.91%
LIVE OAKS HOSPITAL	50.25%	55.41%	56.00%
LORIS COMMUNITY HOSP	41.80%	52.35%	49.09%
MARION MEMORIAL HOSP	32.17%	43.98%	38.36%
MARLBORO PARK HOSPIT	56.58%	56.59%	42.32%
MULLINS HOSPITAL	36.64%	47.59%	45.57%
NEWBERRY COUNTY MEM	39.94%	58.78%	45.78%
OCONEE MEMORIAL HOSP	32.82%	55.29%	45.32%
ORANGEBURG-CALHOUN R	32.32%	47.07%	41.75%
SELF MEMORIAL HOSPIT	34.60%	49.28%	40.40%
SOUTHLAND MEDICAL CE	29.66%	48.59%	32.83%
ST EUGENE COMMUNITY	28.27%	39.66%	37.89%
TUOMEY HOSPITAL	30.10%	46.01%	44.14%
WALLACE THOMSON HOSP	38.32%	52.99%	51.85%
WILLIAMSBURG CNTY ME	27.18%	37.69%	25.80%
WILSON CLINIC AND HO	43.56%	48.13%	37.88%
RURAL COMMUNITY HOSPITALS	34.06%	47.22%	42.15%

Source: Joint Annual Report of Hospitals, South Carolina -- 1987

CHART # 2B

RURAL COMMUNITY HOSPITALS, SOUTH CAROLINA -- 1987

HOSPITAL	% MEDICAID DISCHARGES	% MEDICAID PATIENT DAYS	% MEDICAID REVENUE
ABBEVILLE COUNTY MEM	12.76%	9.74%	8.23%
ALLENDALE COUNTY HOS	21.18%	16.86%	18.37%
BAILEY MEMORIAL HOSP	9.74%	6.54%	7.71%
BAMBERG COUNTY MEM H	19.30%	15.02%	16.20%
BARNWELL COUNTY HOSP	23.31%	14.72%	10.46%
BEAUFORT MEMORIAL HO	14.97%	13.87%	13.07%
BYERLY HOSPITAL	15.00%	1.48%	12.38%
CHEROKEE MEMORIAL HO	14.43%	9.64%	8.30%
CHESTER COUNTY HOSPI	19.01%	11.97%	9.97%
CHESTERFIELD GEN HOS	22.47%	18.85%	16.75%
CLARENDON MEMORIAL H	27.44%	20.14%	16.34%
COLLETON REGIONAL HO	15.86%	13.63%	15.39%
CONWAY HOSPITAL	8.22%	7.28%	7.08%
EDGEFIELD COUNTY HOS	14.28%	6.32%	11.69%
ELLIOTT WHITE SPRING	14.47%	6.61%	7.96%
FAIRFIELD MEMORIAL H	11.16%	6.50%	13.29%
GEORGETOWN MEMORIAL	14.99%	11.96%	9.73%
HAMPTON GENERAL HOSP	18.93%	14.42%	16.64%
HCA GRAND STRAND GEN	2.72%	2.50%	2.79%
HILTON HEAD HOSPITAL	1.12%	1.54%	1.40%
HOPE HOSPITAL	0%	0%	0%
KERSHAW COUNTY MEM H	10.43%	9.31%	6.76%
LAURENS DISTRICT HOS	8.47%	6.93%	6.97%
LEE COUNTY MEMORIAL	34.83%	14.74%	9.46%
LIVE OAKS HOSPITAL	18.57%	23.00%	15.35%
LORIS COMMUNITY HOSP	20.99%	16.39%	15.76%
MARION MEMORIAL HOSP	25.85%	13.91%	14.58%
MARLBORO PARK HOSPIT	17.12%	13.84%	7.54%
MULLINS HOSPITAL	14.16%	13.15%	11.99%
NEWBERRY COUNTY MEM	8.55%	7.59%	9.66%
OCONEE MEMORIAL HOSP	5.48%	3.75%	3.53%
ORANGEBURG-CALHOUN R	16.14%	11.57%	10.33%
SELF MEMORIAL HOSPIT	15.64%	12.92%	9.80%
SOUTHLAND MEDICAL CE	23.75%	14.91%	22.28%
ST EUGENE COMMUNITY	13.82%	13.83%	11.01%
TUOMEY HOSPITAL	22.34%	15.64%	10.87%
WALLACE THOMSON HOSP	12.81%	5.45%	6.76%
WILLIAMSBURG CNTY ME	36.42%	31.73%	29.30%
WILSON CLINIC AND HO	20.91%	11.41%	11.15%
RURAL COMMUNITY HOSPITALS	15.88%	11.68%	10.77%

Source: Joint Annual Report of Hospitals, South Carolina -- 1987

STATEMENT OF THE NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

(SUBMITTED BY MARTHA MCSTEEN, PRESIDENT)

My name is Martha McSteen and I am President of the National Committee to Preserve Social Security and Medicare. As many as one third of the National Committee's five million members live in rural areas and so have a stake in the survival of local hospitals if they are going to have access to health care. We want to commend you, Mr. Chairman, for your leadership in developing a solution to this problem. Your State of Texas has been hit particularly hard, losing ten percent of rural hospital beds during this decade.

> The National Committee endorses the Equity for Rural Hospital Act (S.306) which you have introduced and pledges to work with you to bring health care relief to rural communities around the country. Most important is the elimination of the 13 percent lower rebursement rate for rural hospitals as soon as possible.

Concern for the State of rural health care is more than justified. During this decade, six percent of the nation's rural hospitals had to close their doors. Even more frightening is the statistic you quoted that as many as 600 hospitals, more than 20 percent of all rural hospitals, will shut down *in the next five years*. If this is allowed to happen, access to health care for seniors, especially for the poor, will decline dramatically.

Many lay the blame for these hospital failures on poor financial management and "inefficiencies." This may be true in some cases. However, research by the Senate Special Committee on Aging during the 100th Congress clearly documents that many of the closings are due to flaws in the Medicare reimbursement system which penalize rural hospitals and to the failure of the reimbursement system to take into account special conditions faced by rural hospitals. Your legislation would address the immediate problems and lay the groundwork for further reforms through additional studies and demonstration projects.

ELIMINATING PAYMENT DIFFERENTIALS

The National Committee agrees with you that Congress can no longer justify lower payments to rural hospitals. Most operating costs do not vary significantly between rural and urban areas. In fact, small rural hospitals frequently do not receive volume discounts and face higher transportation costs than some urban hospitals. We support your efforts to eliminate this payment differential as soon as possible.

While a lower wage scale may exist for some rural hospitals, some rural hospitals compete for labor in a market that includes urban areas and wage scales. So we are as disappointed as you that the Administration has failed to exercise its administrative authority to grant relief to rural hospitals in this situation. However, we are not surprised that the Administration has ignored this inequity in favor of saving money. No wonder it is necessary to create a Medicare Geographic Classification Board to review hospital complaints about the geographic classification.

INTERIM PAYMENTS TO VULNERABLE RURAL HOSPITALS

Those hospitals most vulnerable have less than 100 beds and are dependent on Medicare for a substantial portion of their revenue. Your legislation recognizes that they need additional guarantees, at least on an interim basis, that Medicare reimbursements will cover reasonable costs. Medicare pays hospitals a fixed fee for each patient according to the diagnosis but ignores severity of illness. With a high reliance on Medicare patients for revenue and a low volume of patients, most small rural hospitals do not have the financial leeway of larger hospitals to absorb the high cost of treating the few severely ill patients. We hope that you will .explore further whether the eligibility criteria will provide protection to all small rural hospitals who would need this protection. Your legislation would limit the guarantees to small rural hospitals dependent on Medicare for more than 70 percent of their revenue. Others have proposed liberalizing the criteria to include small rural hospitals dependent on Medicare for more than 50 percent of their revenue. Even the more liberal eligibility criteria would only cover 3.5 percent of rural hospitals, according to data from the American Hospital Association.

INNOVATIVE IDEAS

The National Committee strongly endorses creative approaches to providing health care in rural areas. Not only are local conditions in many rural communities different than in the nation as a whole, but rural society is changing dramatically. Yet one of the problems of a national health care program is the difficulty in responding to local conditions and changes in society. Medicare must make a conscious effort to be adaptable and to encourage experimentation in health care delivery through demonstration projects such as the ones authorized by your legislation.

NEED FOR ADDITIONAL STUDIES

Your legislation authorizes a number of studies necessary to fully analyze the fairness of the Medicare reimbursement system for rural hospitals and to develop a methodology for eliminating payment differentials. The timeliness of these reports is essential to enable Congress to eliminate payment differentials as soon as possible. Unfortunately, the Administration's track record on completing these reports in a timely manner leaves something to be desired. For example, we are disappointed that Congress must legislate once again to direct the Secretary of Health and Human Services to develop a methodology to reflect the severity of illness of different patients within the same Diagnosis Related Group. Congress first asked the Secretary for this report in 1986 legislation to improve the quality of care for Medicare patients in hospitals. The report is now six months overdue.

INCREASE HEALTH CARE PROFESSIONALS IN RURAL AREAS

Efforts to protect rural hospitals must go hand in glove with efforts to attract health care professionals to rural areas. Your legislation expands demonstration projects designed to expose doctors and nurses to rural health care experiences. We hope that your Committee would consider other proposals to attract health care professionals to rural areas.

CONCLUSION

The National Committee is looking forward to legislation this year to help bring relief to rural communities around the country. The Equity for Rural Hospitals Act is a promising start.

STATEMENT OF THE RURAL REFERRAL CENTER COALITION

PURPOSE/INTRODUCTION

The Rural Referral Center Coalition is an informal group of approximately 90 hospitals that are rural referral centers ("RRCs") under the Medicare Prospective Payment System ("PPS"). The Coalition has formed to serve as the unified voice to address the critical issues facing RRCs under PPS. The Coalition supports proposed legislation (S. 243) that would maintain the status quo under Medicare with respect to current RRC reimbursement and eligibility until such time as comprehensive changes are made to PPS which will result in equitable and adequate Medicare reimbursement for all hospitals.

We appreciate that the Committee faces a formidable and immediate challenge as to how to save our nation's most vulnerable financially distressed rural hospitals. We wholeheartedly support the initiatives in the Equity For Rural Hospitals Act of 1989 (S. 306) that would help achieve this goal. However, we also believe it is incumbent upon the Committee to act to preserve RRCs, the linchpins of the rural health care network. RRCs fulfill the critical role of providing access to specialized health care services in rural areas. Further, as other rural hospitals reduce their capacity or close, RRCs' importance as providers of health care in rural communities has intensified.

BACKGROUND ON RURAL REFERRAL CENTERS

In enacting the original PPS legislation, Congress specially created a category of "regional" or "rural" referral centers in recognition of the fact that some rural hospitals provide specialized health care services which entail greater costs than other rural hospitals' services. More specifically, Congress recognized that the costs per case of these hospitals were likely to be closer to those of an urban hospital than those of a typical rural hospital.

RRCs treat more severely ill patients and receive cases that tend to be more complex, and thus, more costly, than those in the average rural hospital. RRCs have a higher case mix, not just among DRG categories, but also within DRG categories. Further, the sicker patients who travel greater distances to larger, more specialized hospitals demand advanced technological services and a broader range of drugs and supplies than are needed in other rural hospitals. RRCs must have the necessary facilities and equipment to provide these specialized services. Moreover, the fixed costs for these facilities is usually spread across a smaller group of patients resulting in higher per case costs.

RRCs also have higher labor costs than other rural hospitals because of the need for more specialized care. For example, if a community had two hospitals, one of which was an RRC, the average hourly rate in the RRC would likely be higher because of the need for more specialized personnel. Specifically, specialized personnel are needed to operate the sophisticated high technology equipment such as MRI devices and cardiac catheretization units commonly found in RRCs.

Further, the medical staffs at RRCs must include a wide range of specialists to treat the variety of secondary and tertiary conditions presented by the patient pool. RRCs, thus, must dedicate additional fiscal resources to attract and maintain specialty staffs.

Congress was aware that these differences might result in systematic underpayment to RRCs under PPS were they to be reimbursed at the same level as other rural hospitals. Therefore, special payment provisions were developed for RRCs to prevent reductions in access to specialized care among the non-urban population.

Presently, in order to qualify for RRC status, a rural hospital must have at least 275 beds or meet each of three criteria set forth in regulations promulgated by the Health Care Financing Administration ("HCFA") in the Department of Health and Human Services ("HHS"). First, its case mix must be equal to, or greater than, the lesser of the median case mix index for all urban hospitals nationwide or the median for non-teaching urban hospitals in their census region. Second, it must have a minimum of 5,000 discharges or the median number of discharges for urban hospitals in its census region. (Osteopathic hospitals need only have 3,000 discharges per year). Third, it must meet one of three additional criteria relating to physician specialty and referral patterns.

HCFA further determines reimbursement methodologies for RRCs. Currently, hospitals that qualify as RRCs are reimbursed based upon the standardized amount applicable to "other urban areas" (e.g. those with a population of less than one million). For FY 89, the other urban rate is only 11% higher than the rate for rural areas. For FY 1990, this payment difference may be even smaller if Congress provides for a higher update for rural hospitals than for other urban hospitals. The standardized amount is then adjusted for differences in area wages using the wage index applicable to rural areas in the State in which the RRC is located.

Currently, approximately 226 hospitals are designated as RRCs. According to ProPAC, RRCs comprise 4% of all hospitals, receive 5% of all PPS payments, and account for 6% of all Medicare discharges.

Pursuant to OBRA '86, all rural hospitals which were designated RRCs as of October 21, 1986 maintain such status through September 30, 1989 (the "grandfather period") without undergoing continuing scrutiny to determine satisfaction of the RRC criteria.

CONCERNS REGARDING RRCS

There has been a general misperception since the enactment of PPS that RRC reimbursement is overly generous. Much of this stems from reports from HHS and its Office of the Inspector General ("OIG") which have concluded that while RRCs are more expensive to operate than other rural hospitals, they are not as costly to operate as urban hospitals. Thus, the reports assert that RRCs are being overpaid and recommend using a lower standardized amount than the full urban rate in calculating RRC payments.

Because the members of the Coalition did not believe the HHS or OIG reports accurately reflect the experience of RRCs under PPS, the Coalition asked the Lewin/ICF consulting firm to examine the reports and conduct an independent analysis of the experience of RRCs under PPS.

The Lewin/ICF report, issued in February, 1989, concluded that these studies, in fact, do not accurately reflect the experience of RRCs under PPS. Lewin/ICF identified several fundamental problems with the reports including: (1) They use data from the first few years of PPS and therefore do not reflect the more recent experience of RRCs under PPS, which has been much worse; (2) They do not consider the fact that under OBRA '87, RRCs are now reimbursed at the standardized rate for urban hospitals located in regions with less than one million inhabitants which rate has been consistently lower than the rate for urban hospitals in large metropolitan areas; and (3) While costs per case were compared, the reports did not examine operating margins which reflect not only costs, but also Medicare payments or revenues which are, on average, lower for RRCs because lower wage rates in rural areas are reflected in the wage index used to calculate payments.

The Lewin/ICF report also found that:

> Such comparisons fail to account for the lower revenues that RRCs receive, primarily as a result of the wage adjustment incorporated into PPS. Furthermore, past studies have focused on cost per case when a comparison of Medicare operating margins would be more valid. Indeed, in FY 1987 for example, RRCs had Medicare operating margins that were lower than urban hospitals as a whole and substantially lower than hospitals in other urban areas. Medicare operating margins in FY 1989 and 1990 are estimated to be negative for all hospitals groups. For RRCs, Medicare operating margins are estimated to be negative 16% in FY 1989 compared to negative 26% for all hospitals.

In addition, the report concluded that RRC costs *are* comparable to those of hospitals in other urban areas and thus RRC payment based on the other urban rate continues to be justified.

This report should lay to rest any lingering concerns that RRC reimbursement is excessive. Unfortunately, RRCs, like all other hospitals, are faring poorly under PPS.

SUPPORT FOR PENDING LEGISLATION

Twenty-eight senators to date are co-sponsoring S. 243, which would extend the grandfather period and prohibit HHS from changing RRC reimbursement until October 1, 1994. We believe there are several compelling reasons to enact this legislation.

First, the criteria which qualify hospitals for RRC status need to be reevaluated; until this is accomplished, all currently designated RRCs should maintain their status under Medicare. As early as 1986, it became clear that hospital marketplace was changing dramatically with possible repercussions for criteria which would entitle a rural hospital to special treatment under Medicare. For instance, as the efficiency incentives under PPS were fully implemented, many hospitals began to see patients on an outpatient basis, thus reducing the number of discharges. In communities where smaller rural hospitals shut their doors, some RRCs found that their case mix index decreased as they began to handle the primary care cases that previously went to the hospitals that closed. Convinced that the original rationale that merited special treatment of RRCs was still valid, Congress decided, during the enactment of OBRA '86, to grandfather all RRCs then qualified through the hospital's cost reporting periods ending on or before October 1, 1989. In the interim, Congress expected that HHS would work with the hospital industry to determine new appropriate standards for RRCs.

In order to assure that this issue was fully considered, Congress, in enacting OBRA '87, specifically required that HHS submit a report to Congress regarding the appropriate criteria and payment rates for RRCs. This report was due by March 1, 1989. Unfortunately, the HHS report has yet to be submitted to Congress. Accordingly, many issues regarding RRC criteria remain unresolved, including:

- How have six years of PPS influenced the provision of, and access to, specialty care in rural areas?
- What criteria should now be used to justify a payment differential to providers of such services?
- How many hospitals would qualify under any such new criteria?
- How many current RRCs would not qualify under such new criteria?
- What impact would the loss of the RRC reimbursement differential have on the availability of health care services and the number of jobs in rural communities now served by RRCs?

Unfortunately, these are all important questions to which little attention has been given. Although HCFA has recently estimated that approximately 25% of all RRCs (e.g. about 60) will lose their status should the grandfather provision lapse, it remains unclear as to exactly which hospitals will be effected. Moreover, it is still unclear what criteria, if any, might be considered to replace the current ones. Clearly, it is no longer appropriate to use criteria crafted before the implementation of PPS, given that PPS has resulted in new realities for rural hospitals. Until these uncertainties are resolved, RRCs should retain their status. Indeed, Congress intent to maintain the status quo until it had the opportunity to adequately reevaluate RRC criteria remains valid today.

Second, given that the validity of the urban-rural differential underlying PPS is currently being challenged, it would be arbitrary and unfair to single out one group of hospitals, i.e. RRCs, for reductions pending a revamp of the whole PPS system. To the extent that the urban-rural differential is phased out (and assuming appropriate adjustments and hold harmless provisions are adopted), there may no longer be a need for the RRC category. However, in the interim, and unless and until these questions are addressed, we believe that allowing hospitals to lose their RRC status would only take a payment system that is already unfair to rural hospitals and make it worse.

Finally, and importantly, enactment of the legislation would require no new revenues since it would maintain the status quo.

We would emphasize that time is of the essence in terms of the enactment of S. 243, whether independently or as an amendment to S. 306. The current grandfather provision expires as of October 1, 1989. Thus, hospitals with October 1 cost reporting periods may be in jeopardy of losing their RRC status as of that date if the grandfather provision has not been enacted by then. Loss of RRC status will result in a devastating reduction in the reimbursement which now permits RRCs to offer and fill the need for a wide range of specialty services in the rural area. Further, expiration of the grandfather provision will result in a significant loss of jobs as well as services, which will only exacerbate the problems with the delivery of health care in our rural communities.

More specifically, several hospitals face the dilemma that they do not know whether they will lose 11% of their Medicare standardized payment as of October 1. It is extremely difficult for these facilities to plan and to make commitments to services and staff in the face of this uncertainty. We would urge the Committee to expedite this legislation to avoid that outcome.

AREA WAGE INDEX

The Lewin/ICF study examined the issue of wages paid by RRCs to those paid by other hospital groups. This analysis suggests that wage rates for RRCs are similar to those of other urban hospitals. In 1984, the wage rate for RRCs was $9.58 per hour, while the wage rate for other rural hospitals was $7.84 per hour. The wage rate for RRCs was 5% lower than for large urban areas, while virtually identical to that for hospitals in other urban areas. Accordingly, there does appear to be justification for paying RRCs based upon the applicable urban wage index. Towards this goal, the Coalition supports the provisions in S. 306 that would establish a Medicare Geographic Classification Review Board. Under these provisions, a rural hospital, including a rural referral center, that believes that it can present a case for receiving the applicable urban wage index would be allowed to appeal to this newly created board. We believe many RRCs would be able to present a very compelling case in this regard. We would urge that the legislation be clarified to assure that RRCs are eligible to avail themselves of this provision.

SUMMARY

The Committee should adopt S. 243, which would extend the grandfather provision and retain current RRC reimbursement levels for a period of five years while the urban-rural differential is phased out.

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